Rebekah Marion Hamman

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Rebekah M. Hamman 4. Facility Name (if not institution, give street and number) University Hospital 5. Social Security Number 10. State 10. State 10. State 10. Street and Number 10. State 10. Street and Number or Number 10. Number of Specify 11. Was Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) 10. Not off the Specify 10. Specify 10. Specify 11. Specify Person No. 12. Waiterss 13. Was Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) 10. Not off the Specify 10. Specif	N/A YY) 9. Birthplace (State or Foreign Country)Maryland 10d. Inside City Limits 1 X Yes 2 No What Country? States ce - American Indian, Black, nite, etc. White Business/Industry taurant ne) own, State, Zip Code)
Rebekah M. Hamman 4a. Facility Name (if not institution, give street and number) University Hospital 5. Social Security Number 6. Sex 215-23-9555 1 M 2 JF 31 Vrs. 100. City, Town or Location 101. State 102. City, Town or Location 102. City, Town or Location 103. State 104. County 105. Social Security Number 6. Sex 215-23-9555 1 M 2 JF 31 Vrs. 105. City, Town or Location 106. Street and Number 107. Age (in yrs. last birthday) 107. City, Town or Location 108. Date of Birth (MM/DD/YYY 13 02/12/1979 13 02/12/1979 15. Social Security Number 105. Street and Number 106. City, Town or Location 107. Age (in yrs. last birthday) 108. Date of Birth (MM/DD/YYY 13 02/12/1979 13 02/12/1979 14. Rac County 15. Social Security Number 16. Sex 17. Age (in yrs. last birthday) 18. Davis Months 19. Davis Min. 19. Davis Min. 106. City, Town or Location 107. Zip Code 107. Zip Code 107. Zip Code 107. Zip Code 108. Date of Birth (MM/DD/YYY 13 02/12/1979 109. State 109. Citizen of V 109. Citizen of V 109. Citizen of V 11	y of Death N/A YY) 9. Birthplace (State or Foreign Country)Maryland 10d. Inside City Limits 1 X Yes 2 No What Country? States ce - American Indian, Black, nite, etc. White Business/Industry taurant ne)
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Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYS. 13 1	9. Birthplace (State or Foreign Country)Maryland 10d. Inside City Limits 1 X Yes 2 No What Country? States ce - American Indian, Black, nite, etc. White Business/Industry taurant ne) own, State, Zip Code)
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4 Donation 5 Other Specify: Metro Crematory, Inc. Flay 5, 2019 Butth 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society 299 Frederick Road, Baltimore, M.	nite, etc. White Business/Industry taurant ne) own, State, Zip Code)
4 Donation 5 Other Specify: Metro Crematory, Inc. Flay 5, 2019 Butth 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society 299 Frederick Road, Baltimore, M.	w White Business/Industry taurant ne) Dwn, State, Zip Code)
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4 Donation 5 Other Specify: Metro Crematory, Inc. Flay 5, 2019 Butth 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society 299 Frederick Road, Baltimore, M.	Oit or Town Chate
4 Donation 5 Other Specify: Metro Crematory, Inc. Flay 5, 2019 Butth 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society 299 Frederick Road, Baltimore, M.	
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Z99 Frederick Road, Baltimore, M	of Maryland, Inc
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failure. List only one cause on each line.	Between Onset and Death
Examiner Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	
Sequentially list conditions, b	
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	
(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
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δ 등급 □ UNPENDED IA AMENDED TO COO 5 /6 /10 TH	
UNPENDED AMENDED #8, per Fh G903 5/6/10 TT FFEMALE: 23d. Date of pregnancy 23d. Date of	
23b. Was decedent pregnant in the past 12 months? Yes 2 No 9 V Unknown Month	Day Year
past 12 months? Compared to the continuous process of the continuou	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	ntribute to the cause of death?
O a graph of the significant conditions contributing to death but not resulting in the underlying cause given in Part II. Yes 2 No 3	3 Probably 4 Unknown
The law requires to the law of th	. Were autopsy findings available prior to completion of cause of
yerformed? 1 ✓ Yes 2 No	death? 1 Yes 2 No
THE SECOND SECON	
examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other4 Nursing Home 5 Residence 6	
27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occu May 1, 2010 Year) 2039 hrs 1 yes 2 No Pedestrian struck by pic	
Natural 5 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Num	barrel David Number City
24a. Was an autopsy performed? 1	Nottingham MD
4 Homicide determined (Specify) Major Road / Highway Bel Air and Dunfield Road, 29a. Certifier (Check only) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner.	
폭트를 즐겁니다. 👱 🕡 Medical Examiner:On the pass of examination and/or investigation, in my opinion, death occurred at the time, date and place, and	due to the cause(s)
and manner stated. 29b. Signature and title of gentifier 29c. License number 29d. Date sig	gned (Month, Day, Year)
O.C.M.E. May 2, 20	110
30. Name and address of person who completed cause of death (Item 23a)	
OCME Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Ernest D. Harden, Jr. Medical 9:05 May 3. 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death **Ellicott City** 751 Oella Ave Howard 5. Social Security Number Funeral 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 1 X M 2 □ F Months Days Hours Director 213-20-3955 84 Sep 21, 1925 Usual Residence of Decedent or 28a-f shov 10a, State 10b. County within 72 hours after death with the Maryland the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 - Yes 2 - No Howard **Ellicott City** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 751 Oella Ave 21043 U.S.A "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1) Yes 2 No 1942

If Yes, Give \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 27 No 1 🗌 Yes Specify 3 Widowed 4 Divorced Completed Year or Dates. 1944 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 2 should be filed within 72 hand Mental Hygiene. 7 is marked other than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) General Electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ernest D. Harden, Sr. Alice G. Tucker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Clair Schaeffer Daughter 751 Oella Ave Ellicott City, MD 21043 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place permit. Page 1 and Department of Plumbortant: If ite any injury or ot 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 08, 2010 Good Shepherd Cemetery Ellicott City, Maryland of Fuheral Service 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part Friter the dis complications that car shock, or heart failure List only one cause on Interval Between Immediate Cause (Final Physician, Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last as the burialattending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Pregnant at time of death 5 Other (specify) Yes 2 No the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? has autopsy this certificate perform 1 Yes 1 Yes 2 🗆 No Be 25. Was case referred to medica 26. Place of Death (Check only one) Other: 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 Yes 2 🗌 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined 28f. Location (Street and Number or Rural Route Number. City or Town, State) within 24 hours a

To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ertifying Nurse Practiseer: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 3 29b. Signature and title cert 29d. Date signed (Month, Day, Year) ress of person who completed cause of death (Item 23a) (Type, Print) Name and Date filed (Month),

DHMH 17 Rev 7/2009

State

Registrar

WD

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 07:22 AM **Physician** DUNALD IRELAND 02 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE HUSPITAL If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days 1 M 2 □ F Maryland 212-42-3593 66 January 26,1944 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State ?7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, "to Modical Exemitar must be notified at 1 X Yes 2 □ No South Baltimore Director Maryland N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 72 hours after death with 21230 U.S.A. 1742 Clarkson Street Funeral 14 Bace - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 2 3 X Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed Carpenter 8 Department of Health and Mental Hygic Important: If item 27 is marked other any injury or other traumatic event, the once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret B. Murray John F. Ireland ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Brother) 8380 Jacqueline Avenue, Manassas, Virginia 20112 Joseph R. Ireland 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Bayview Crematory 05-06-10 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully-Polyniak Funeral Rone P.A. 21. Signature of Funer Price Licensee 130 East Fort Avenue, Baltimore, Maryland 21230 N. Approximate Interval Between Onset and Death 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each, or heart failure. List only one cause on each line. diate Cause (Final ease or condition resulting in death) ARDTOMYOPATHY -10 years **Physician** /Medical Due to (or as a consequence of) 20 OBSTRUCTIVE PULMUNARY DISEASE Examiner END-STAGE CHRUNTC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atte Month Year Day in the past 12 months? 5 Other (specify) □Yes 2□No 9 Dunknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed/ Yes 2 No after death.

Director: After this certificate the principle of the control of th 1 ☐ Yes 2 ☑ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 1 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated To the I within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAJAT BALTIMORE, MD 21-225 HANOVER ST. 3001 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 05 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Bernard Johnson Month 2 Pay Zo 10 10:50A M Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Thucst town Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, 1 Year If Under 24 Hrs **Funeral** 9. Birthplace (State or Foreign 1 M 2 □ F Director ine Usual Residence of Decedent or items 23a or 28a-f shov 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits TIME 1 Nes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral WOOD 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Completed 3 Divorced 4 Divorced lack 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Eather's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname ျှ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, wood 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signat0re of Funeral Service Licensee 22. Name and Address of Facility M 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such secardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Atheroscientic Grdiovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a nonsequence of): Exam signed by the attending physician and a be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 23e. Did tobacco use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s autopsy 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To 1 🗌 Yes 2 🗆 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other Specify the 1that pice 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1
Yes 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MSKujapakseMD. D0057465 4/29/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) "AV-5-703, Baltimore, MD, 21209 2835 Smith · Rajupakse, MID 31. Date filed (Month) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Year Month JOHNSON 5:31 OBERT MAY 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death UNIVERSITY OF MARYLAND MEDILAL LINTER Baltimore N/A Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Min. 1 207 7 34 / 1 9 4 1 Maryland Director 219-38-2542 68 Yrs Usual Residence of Decedent 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Funeral Director ms 23a or 28a-f s must be notified 1 X Yes 2 ☐ No N/a MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21201 U.S.A. 22 S. Greene Street 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 ☐ Yes 2 🔀 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Black Year or Dates marked other than "natu matic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Unemployed unknown unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Johnson Beatrice unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2127 Scarbrough Rd., Stone Mountain, GA30088 Department of Health Important: If item 27 any injury or other to Antoine Geathers(Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 05/05/10 Baltimore, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses ²វ្វីបិទ្ធិទីក្រៅ អ៊ុល Funeral Home 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ PNEUMONIA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Destilemia IDAY Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of): attending physician and I for use as the burial-transit Cause (Disease or iinjury YEARLS OPP that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month After this certificate has been signed by the signeral director, page 2 should be detached to P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 3 Probably 4 Unknown To Be Completed 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 🗌 No 1 Tyes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this nartifact within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, i 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural injury 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number Kemuta D. Gilimban 1962637892 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

KENNETH D EXCHENSAUM

31. Date filed (Month, Day, Year)

22 SOUTH GREEN STREET BALTIMORE MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Physician/ Richard Cameron Johnson Month 1:25 P. M May 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Towson Gilchrist Hospice If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 Å M 2 □ F Days Min 68 Yrs 215-40-6060 8/13/1941 Kentucky Director Usual Residence of Decedent show 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location 10d, Inside City Limits Director Maryland Baltimore Parkton 1 Yes 2 No 10g. Citizen of What Country? United States 10e. Street and Numbe 10f. Zip Code Funeral 1515 Jordan Sawmill Road 21120 of America 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. and 2 should be filed within 72 hours after d Health and Mental Hygiene. tem 27 is marked other than "natural", or i þ XX Never Married 2 Married Maryland 21215-0036 white 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Transit Department Baltimore City any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Vera Miriane Engel Allan W. Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald R. Hull/ POA 526 Baltimore Blvd. Westminster, Maryland 21157 permit, Page 1 and 2 Department of Healt Important: If item 2 Baltimore, 20a Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State Evans Funeral 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Chapel- Bel Air 2010 4 Donation 5 Other (Specify) Forest Hill, Maryland 21. Sign Funeral Servi Peaceful Alternatives Funeral & Cremation Center, P.A. 2325 York Road Imonium, Maryland 21093 23a. Part/. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a conseque ce of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Due to (ur as a consequence or) sician and burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day Pregnant at time of death 2 No ed by the a 9 Unknown g 🗌 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. signed by 23e. Did tobacco use contribute to the cause of death? Completed by 1 Probably 4 Unknown Records, page 2 should been Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy death? perform 1 Yes 2 No Yes 2 Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital director, Be examiner? 2 XNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir မ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending injury 1 Natural 2 Accident 3 Suicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year)

State Registrar

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ____2<u>010</u> Physician/ Month Paul W. Jenkins 1:30 Ам 30 April Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Riverdale Prince George's 5901 Roanoke Avenue 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Yea 9. Birthplace (State or Foreign **Funeral** 1 ፟ M 2 □ F Days Hours Ouicksburg, VA 226-12-0538 93 **Director** Yrs September ,1916 Usual Residence of Decedent 10b. County 10a. State filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f s notified Maryland Prince George's Riverdale 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ural", or items 23a o Funeral 5901 Roanoke Avenue 20737 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give WWTT 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced WWII Specify: White Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) DC Transit (Metro) 12 Bus Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) i. Page 1 and 2 should be file tment of Health and Mental H tant: If item 27 is marked o jury or other traumatic eve and Mental h ဂ္ John C. Jenkins Anne V. Olinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John S. Jenkins / Son 814 Copley Avenue, Waldorf, MD 20602 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department or Important: If any Injury or once, 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 5/6/2010 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, PA Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Cardiopulmonary Arrest Medical Due to (or as a consequence of): **Examiner** Hypothryodism Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Physician: The law requires that the death certificate be executed Cause (Disease or iiniury Glomerulonephritis that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Day Pregnant at time of death 5 Other (specify) Month Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page performed death? 1 Yes 2 No Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 X No Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🛛 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Hospital or Attending Pl 24 hours after death. Funeral Director: After the Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pendina Accident Investigation 1 Yes 2 🗌 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined

P.O. Box 68760 Records, Division of Vital 24 hours

21215-0036

Baltimore, Maryland

Registrar

Mi Na Son, 6525 Belcrest Road, Hyattsville, MD 20782 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical

29a. Certifier

only one) 29b. Signati

🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3. 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 28 pay 2010 4:28 PM Zevart Η. Jamgochian April Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Manor Care Nursing Center Wheaton Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Pay, Yead)
Aug. 4, 1934 Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 😾 Lebanon 266-25-8506 **Director** 75 Usual Residence of Deceden 28a-f show 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Montgomery Silver Spring 1 Yes 2 X No ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 14510 Homecrest Rd. 20906 United States items death v 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ō 1 X Never Married 2 Married þ Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2X No Specify. White "natural", Specify: Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Medicine Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be Hrant Jamgochian Sirarpi Lachinian other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Dicran Jamgochian / Brother 5347 28th St. NW, Washington D.C. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State injury or Chesapeake Crematory 5/1/2010 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Ser 23. Name and Address of Facility
Rapp Funeral and Cremation Services M00382 any The Dohmon 933 Gist Ave., Silver 20910 Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Pπysician/ Cardiac Arrhythmia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause Ent r Linday Due to (or as a consequence of): sician and burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical The law requires that the death certificate be Box 68760 s the b IF FEMALE use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No for Month Pregnant at time of death the be detached 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 ☐ No 3 ☐ Probably 4 Unknown Completed 1 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy perform certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, i Division of Vital Physician; 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred or Attending Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifie (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar

State

31. Date filed (Month, Day, Year,

ss of person who completed cause of death (Item 23a) (Type, Print)

5

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 20b, c per fh g903 5-18-10 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 07:59 AM WESLEY JOHNSON JAMES MAY 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARBOR HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 XM 2□ F Days Director Yrs 218-14-1437 Usual Residence of Decedent 87 31 23 MD 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits show of Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be a clifted at Director 1X Yes 2 □ No MD Baltimore NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1104 Montcalm Ct. Funeral 21225 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1√Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Š Specify: Black 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within ; th and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Painter Wallace H. Campbell na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John W. Johnson Alice Garrett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1104 Montcalm Ct., Baltimore, Md 21225 Eric Johnson-Son 20b. Place of Disposition (Name of Crownsville Crownsville Garrison Forest Vet 5/12/20 10 Owings Mills, Md 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot Burial 2 Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter it a disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. FND - STAGE RENAL DISEASE Approximate Interval Between Onset and Death Physician 3 months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) y physician and is the burlal-transit law requires that the death certificate be exec Due to (or as a consequence of) Box 68760, Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.O.1 signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Tilnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Was a autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 The certificate 1 □ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral dir Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) To the I and manner stated

State Registrar PRASANTI GANNI 31. Date filed (Month, Day, Year) MAY 05 2010

Propanti Hanni

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



29c. License number

RES-001

29d. Date signed (Month, Day, Year)

May 3,2010

			Pleas	e Type or Pri										
			For State Registrar	State of M	arylan		artmen rtificate			Mental H	ygiene Reg. N	from the	10	14010
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	Medic Examin		4a. Facility Name (if not institution, gi	ve street and number)			4b. City,	Town, or	Location of Dea				of Death	A
	Funeral Director			Sex 7. Age 1 M 2 D F	e (In yrs. la	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hr. Hours Min	8. Date of B	irth		g. Birthp	place (State or Foreign
			Usual Residence of Decedent		81					107710	19	20	Mary	/Ianu
	aryland a-f sho fied at	Director	MD Anne A	rundol	10c. City	/, Town or Lo	Glen Burnie						1	0d. Inside City Limits
	a or 28 be noti		10e. Street and Number	runder			10f. Zip		Surine		10g. C	itizen of	What Cour	
	ath with	Funeral	327 Kess Circ		12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 ☒ 1 ☐ Yes 2 ☒				1060 nt of Hispanic Origin? (Specify Yes or No- y Cuban, Mexican, Puerto Rican, etc.) No Specify:			U.S.A.		
036	e filed within 72 hours after death with the Maryland that hygiene. 3d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	Marital Status Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?				ity Cuba				14. Race - American Indian, Black, White, etc. Specify: Black		etc.
15-0	72 hour	Completed	15. Decedent's (Specify only highest			16a. Dece	kind of wor	k done d	ation luring most of wo	orking	16b. l		usiness Inc	
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D	e filed ntal Hy ed oth event	To Be	17. Father's Name (First, Middle, Last	,			_			me (First, Middle	e, Maiden	Sumam		
aryk	should be file h and Mental 7 is marked of traumatic eve		Russell Ke 19a. Informant's Name/Relationship		-	19h Mailie	no Address	/Street a	Ellen	M . C			State 7in (ande)
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Baltimore,	permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3		C	lace of Dispo	natory or o	ther place		Date	1		- City or To	
altir	permit. Pag Depertmen Important: any injury once.		4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Lice		IST.	Res				08/10			er,MI	
8	e e e		20 Det 1 Establishers	hV. Wil	lear					Jr. F Ave., E		imor	re,Mi	5 21217
L) p	าเงูรเรเลก		23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line	ne deatr				ACU O		irrest,			Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	a. Due to (or as a	consequ		ист	~	rica o	ENI			\neg	
		iner	Sequentially list conditions,	b. Due to (or as a	nonsequ	eribeicty:								
7 p.	executed ian and inal-transit	Examine	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a	CORSOCI	ence off:								
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× 68760	Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Funeral Director: After this certificate has been signed by the attending physici sted filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy						23d. Date of deli			ery
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ital .	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:				Othe	ce of Death (Che	eck only one)				
o	ding Phy th. After this funeral d	ite: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injur (Month, Day	у	ER/Outpatier 28b. Time of injury		Bc. Injury work	4 Nursing l	Home 5 Res 28d. Describe				
Division of Vital	of or Attendia after death. Director: Af d in by the fu	Certificate:	2 Accident Investigati 3 Suicide 6 Could not	on be 280 Place of this			M not footon	1 🗆 '	Yes 2 No					
DIV	pital or A ours after eral Direc filled in by		4 Homicide determine	building, etc	(Specify)					City or To	wn, State	e)		Route Number,
:	To the Hospital of within 24 hours at To the Funeral D completed filled in	Medical	(Check 2 L. Medical Example 12 L. Medical Ex	ysician: To the best of a miner: On the basis of ex urse Practioner: To the l	amination	and/or invest	tigation, in r	nv opinio	 n. death occurred 	at the time date	and place	and due	e to the call	se(s) and manner stated
	To t To t		29b. Signature at title of certifier	าอ	M	0	29c.	License	rumber 4574	Î	29d. Da	ate signed	d (Month, E	Day, Year)
	2		30 Ann and address of person who		eath (Item	23a) (Type, P		dr	ne (Flen	Bu	Nno	e.N	10 20161
ı	Stat Registra		31. Date filed (Month, Day, Year)	32. Registra	r's Signati	_	les!							

LARRY WENDELL KENNEDY
10-03136 Please

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

JNK UNK		I- For State Registrar	State of Maryla		partment of ertificate of		nd Ment	tal Hyg		eg. No. 21	011	0 14.01
Physicia Medical Examin	n/	1. Decedent's Name (First, Mid	dle,Last) /ENDELL		KENN	EDY			Date of Deat Month April 22, 2	Day Yea	ir	3. Time of Death 1120 hrs
		4a. Facility Name (if not institut 2723 Country Club F	-	umber)		4b. City, Town, o Landover	or Location o	f Death	-	4c. County of Prince C		's
Funeral Director		5. Social Security Number 578-96-5164	6. Sex	7. Age (In yrs	s. last birthday) Yrs	If Under 1 Ye Months Da				th(MM/DD/YYYY 9 1962		hplace (State or Foreign SHINGTON, DC
ow any	Ī	Usual Residence of Decedent 10a. State 10b. Count	E GEORGE'S		ity, Town or Locat							10d. Inside City Limits 1 X Yes 2 No
e Maryland or 28a-f show	Director	MD PRINC 10e. Street and Number 4077 WARNER			ANDOVEK	10f. Zip Code 2078	4		10	Og. Citizen of Wh	nat Coun	
15-0036 filed within 72 hours after death with the Maryland I Hygiene. Is other than "natural", or items 23a or 28a-f sho i, the Medical Examiner must be notified at once,	_ L	11. Marital Status 1 X Never Married 2		cedent Ever in orces?	If Y	s Decedent of H es, specify Cuba					- Americ e, etc.	can Indian, Black,
	اھ	15. Decedent's Education (Sp		de completed)		Yes 2 X No t's Usual Occupa ost of working life	ation (Give k			Specify:		
1215-0036 d be filed within 72 hours after fental Hygiene. rarked other than "natural", event, the Medical Examiner	Completed	9TH 17. Father's Name (First, Middl		1-4 or 5+)	N	IONE	18.Mother's	s Name (F	irst, Middle, N	NONE)	
D 21215-C should be filed v and Mental Hygi 7 is marked oth	å	MACK HUGHES 19a. Informant's Name/Relation	nship (Type, Print)				eet and Numl		al Route Num			Zip Code)
≥ pd a m bd 2 ≥ m m	1	VIRGINIA KEN 20a. Method of Disposition 1 Burial 2 Crematic	· ·	20t om State	o. Place of Dispos crematory or oti	ition (Name of cener place)	emetery,	С	Date	VER HIL	City or 1	Fown, State
Baltimore, bernit. Pages 1 an Le artment of He Important: If ite	-	4 Donation 5 Other 21. Signature of Funeral Service		R		lame and Addres	ss of Facility		B. JEN	KINS FU	NERA	
Physician /Medical	1	23a. Part I. Enter the disease, of failure. List only one caus	e on each line.		th. Do not enter the	74 I.AND ne mode of dying	OVER I g, such as ca	ROAD ordiac or re	I.ANDOV espiratory arre	ER MARY est, shock, or hea	LAND	20785 Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final diseas or condition resulting in death) Sequentially list conditions,	Due to (or as a		xication of):	t						
	miner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	c.									
executed an and al - transit	dical Ex	events resulting in death) Last XUNPENDED	d			- 222	= 16.11	0 77				
ox 68760 ath certificate tattending phys	影	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)							23d. Date of Month	delivery Da	ay Year	
ords, P.O. w requires that the lis been signed by the should be detache	۵	Part II. Other significant cond	itions contributing to	death but not	t resulting in the u	nderlying cause	given in Par	t I.	1 Yes	2 No 3	Proba	he cause of death?
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Vital Rec	a	25. Was case referred to medic examiner? 1 ✓ Yes 2 No	Ulassital, 1779	npatient 2	ER/Outpatient		of Death (Residence 6 v	Other:	Scene
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the sale of death of the this certificate has been signed by led in by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted in the funeral director, page 2 should be detacted in the funeral director, page 2 should be detacted in the funeral director, page 2 should be detacted in the funeral director, page 2 should be detacted in the funeral director, page 2 should be detacted in the funeral director, page 2 should be detacted in the funeral director.	ation: To	27. Manner of Death 1 Natural 5 Per	28a. Date (Month		28b. Time of la Fd 11:0	`` ₁┌┌	ury at Work?	No u1	d. Describe h	ow injury occurre	ed	
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To the Hospital within 24 hours To the Funeral completely filled	edical	one) 2 Medical Ex	Physician: To the bes aminer:On the basis of and manners	of examination		on, in my opinio	n, death occ			and place, and di	ue to the	cause(s)
		29b. Signature and title of certif	M	1	15	29c. Licen:	.M.E.			April 23, 20		m, Day, Year)
$\emptyset \sqrt{}$		Zabiullah Ali, M.D.	Assistant Medic	al Examine	er 111 Pen	n Street, Bal	timore, M	ID 2120	1			
Sta Registr		31. Date filed (Month, Day, Year	5 2010 32. Re	eo trads Signa	ature	and I						
DHMH 17 Rev 1/200 OCME 2006	01				ORIGINAL	Mires						OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 2310 **Physician** lichae 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner Baltimore City** N/A The Johns Hopkins Hospital Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Ye April 30, 6. Sex 1 X M 2 F If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In vrs. last birthday) 5. Social Security Number Year **Funeral** Days Months 1940 Maryland 217-38-4102 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d, Inside City Limits 10c. City, Town or Location 10h County 10a. State 1 Yes 2 □ No Maryland N/A **Baltimore** Director 10g, Citizen of What Country? 10f. Zip-Code 10e. Street and Number 21230 1614 Clarkson Street USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 Yes 2X No Baltimore, Maryland 21215-0036 Specify: Specify: White þ 3 X Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Johns Hopkins Hospital Research Technician unknown unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Laura Bunger Ilarien Kluka 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6120 Medora Rd., Linthicum, Maryland 21090 Patricia Ann Vanskiver (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 5/7/10 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kevin E Ecker 3204 Mountain Rd., Pasadena, Md. 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -ardiogenic **Physician** disease or condition resulting in death) Due to (or as a consequence of): /Medical **Examiner** Lepis Sequentially list conditions, if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cerebral Artery Stroke Middle burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? be detached for Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by No 3 ☐ Probably 4 ☐ Unknown 1 Tes the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? Was an autopsy performed? 24a. Was an this certificate has 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 3 🗆 DOA 2 ER/Outpatient ၉ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation Injury 1 Natural 1 🗌 Yes 2 □ No Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide

Division of Vital Records, P.O. Box 68760, al or Attending Physician: s after death. Director: After this certifica completely filled in by Hospital 24 hours a Funeral D To the Ewithin 2

31. Date filed (Month, Day, Year) State 05 Registrar

29a. Certifier

(check only one)

29b. Signature and title of certifier

Medical

124 9 9 32. Registrar's Signature 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month Mac (0: 53 AM Kotov 2010 /Medical 4a. Facility Name (If hot institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hopking Bayview Medical Conter ecurity Number 6. Sex 7. Age (In vis last hirthdo N/A Baltimon If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) OCT. 24,1954 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** Days Months Hours 1 XM 2 □ F ÜKRAINE 215-45-9444 Director 55 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f show Director 1 ☐ Yes 2X No MD HARFORD BEL AIR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 479 MOORES MILL RD. 21014 APT. #3 U.S.A. by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status 1 ∐Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 1∐Yes 2XNo Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5 + Elementary/Secondary (0-12) **ENGINEER** DAIRY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ant of Health and Mental Hit: If item 27 is marked oth y or other traumatic even Be Pages 1 and 2 should be nent of Health and Mental YAKOV KOTOV N/A ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VICTORIA KOTOVA/WIFE 479 MOORES MILL RD., APT. #3, BEL AIR, MD 21014 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If i any Injury or Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ANDREWS CEMETERY 5/4/10 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
LILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Intravascular Coaquilation a Disseminated 2 days disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** adeno carcinoma 6 months 7astric Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Ye ar P.0. signed by the a 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe Division of Vital 1 ☐ Yes 2 No 2 □No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1∐ Yes 2 🗹 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death al or Attending P s after death. ai Director: After After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □Yes 2 □ No 2 Accident filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) J. H RES-000 1, atte 2010

10

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

SMITTA

33

PATEL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D. 4940 Eastern
32. Registrar's Signature

ORIGINAL

Avenue

Baltimore MD 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month i 9010 1145 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** County of Death Heatth and Ker TINCE 7. Age (In yrs. last birthday) 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 👿 F Months Davs Hours Min. Director Usual Residence of Decedent or items 23a or 28a-f show 10a. State within 72 hours after death with the Maryland 10b. County 10c. Çity, Town or Location event, the Medical Examiner must be notified at 10d. Inside City Limits Director trince reorges 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20 Qr 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Yes 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates ASIAN "natural" 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b., Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) OUSE WIT Be and 2 should be filed 17. Father's Name (First, Middle, 18. Mother's Name (Fi<u>rst. Middle,</u> Maiden Sumame) ဂ္ ليلا 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, permit. Page 1 and 2.2...
Department of Health an Important: If item 27 is aure 00 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) FUNERAL HOME Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events Unit to for as a nonsequence of: To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy page 2 should be detached for Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate has l completed filled in by the funeral director, page 2 s performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check D006253 hewan, I 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9055 Cherto DHAWAN 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

■ Baltimore. Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

	1 - State Registrar					Ce	rtificate	e of L	Death			Reg. No	o. 2		11	01
an	1. Decedent's Nam	e (First, Middle	le, Last)								2. Date of I	Death Da	av	Year	3. Time o	f Death
cal	Bette Li							_			Apri		3	2010	9:00	Α
er	4a. Facility Name (If not institution	n, give stree	t and number	r)		4b. City, 1	lown, or	Location	of Death		40	c. Count	ty of Death		
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	5. Social Security N		6. Sex 1 ☐ M			last birthday) Yrs.	Months		Hours Hours	r 24 Hrs. Min.	8. Date of I (Month, July 1	Birth Day, Year	20	9. Birth Cou Ohi	place (State intry)	or Fore
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	10a. State	10b. County			10c, Cit	y, Town or Lo	cation								10d. Inside C	ity Lim
ţ	MD	Talb	ot		В	ozman	n								1 ☐ Yes	2
Director	10e. Street and Nur	mber			.1		10f. Zip	Code				10g. C	itizen of	f What Cou	ntry?	
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	1 Never Marr		l If	rmed Forces Yes 2 X Yes, Give	No		1 ☐ Yes 2		Specify		riican, etc.)			ack, White, _{ify:} wh:		
d by	3 Widowed	4 Divorced	Ÿ	ear or Dates:	:				0,000)							
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E D	Elementary/Seco	ondary (0-12)	С	college (1-4or	5+)		DO NOT use t ist	e retired)							
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	20a. Method of Dis	position			20b. P	lace of Dispo	osition (Name	e of			Date	20c. L	ocation	ı - City or Tı	own, State	
	1 ☐ Burial 2	□ Cremation		val from State	1 ^	emetery, crei	matory or oth	her place	e) ;					,	,	
	4 Donation			A.		2:	2 Name and	1 Addres	e of Facil	ity						
	21. Signature of Fu	nald S	Way	Dice	ecter								Ва	Ltimo:	re Str	eet
	3a. Part . Enter t	he disease or	complication	ns that cause	ed the death	Do not en					nd 212				Approxima	te
	show, or hea	he disease, or art failure. List (Final	only one car		1 0		101 1110 1110 11	or a ym	g, odom a	o our diao	or respiratory	y uncor,			Interval Be Onset and	tween
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	resulting in death)		_ a		_										6 mini	117
	resulting in death)		(a	Due to (or a	da consecu	ience of/:	. Aic	PIIS	,							dec
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician/ PATRICIA LANGREHR-ROSTEK 2010 6:10 P.M MAY Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** BALTIMORE TOWSON GILCHRIST CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Min (Month, Day, Year) 2/13/1962 1 🗆 M 2 🗶 F 212-48-7250 47 MARYLAND Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 V No BALTIMORE PARKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8391 ARBOR STATION WAY APT. USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 1 ☐ Yes 2 X No If Yes, Give Year or Dates. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: WHITE Completed 3 Widowed 4X Divorced other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) MANUFACTURING ASSISTANT INSPECTOR 12TH GRADE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္ပ JOSEPH A. DYSON VIRGINIA ANN MILLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOSEPH A. DYSON/FATHER QUEENS FERRY RD. BALTIMORE. MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Termation 3 Removal from State 4 Donation 5 Other (Specify) any injury or CREMATORY. INC 5/5/2010 CATONSVILLE, MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee MO0217 8521 LOCH RAVEN BLVD. TOWSON. MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ n Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innerial director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Dav Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) **Division of Vital** Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tes ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation is my relief Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W State Registrar

DHMH 17 Rev 7/2009

Box 68760

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2010 Physician/ Month May Howard Lourie 3:45 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 3205 Rolling Rd. Chevy Chase Montgomery 8. Date of Birth 10 (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1938 Country)
ew York Months 1 🔯 M 2 🗆 F 577-52-7498 Director 72 New Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at **Funeral Director** 28a-f Montgomery Chevy Chase 1 🗌 Yes 2 🔀 No 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3205 Rolling Rd. 20815 United States items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No
If Yes, Give 1068, 75 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Completed by Black, White, etc. 1 ☐ Never Married 2X Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", Specify: 3 Divorced 4 Divorced r Yes, Give Year or Dates 1968-71 White traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Private Medical Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Practice Physician item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Reginald Spencer Lourie Lucille Radin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Florence Lourie / Wife 3205 Rolling Rd., Chevy Chase, MD injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State Chesapeake Crematory 5/4/2010 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD 21. Signature of Funeral, Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD Gist Ave., Silver Spring, MD 20910 Human 23a. Part 1. Ent. r the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death
Years Physician/ Hepatic Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Chronic Hepatitis 20 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): burial-transi Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death signed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Arteriosclerotic Heart Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Diabetes 24a. Was an page Renal Failure 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 Natural 5 Pending Accident Investigation the 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by ti Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Pertifying Nurse Practions. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number

1941

State 31. Date filed (Month, Day, Year)
Registrar NAY 0.5.2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Lindsau Randol ohn 1300 М Medical 2010 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner b. City, Town, or Location of Death Howard County General Hospital Columbia Howard Social Security Number 8. Date of Birth (Month, Day, Oct . 28 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Days Hours North Carolina 87 246-18-0265 Director Yrs. Usual Residence of Decedent 28a-f shov 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No Maryland Ellicott City Howard 10e. Street and Number 10g. Citizen of What Country? 23a Funeral 21042 9713 Longview Drive United States 12. Was Decedent Ever in U.S. Armed Forces? 1941—11 (1941—11) Armed Forces? 1941—11 (1941—11) Armed Forces (1941—1 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Ith and Mental Hygiene. 27 is marked other than "natural", or iter traumatic event, the Medical Examiner. Completed by 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Merchant Seaman Merchant Marines Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Page 1 and 2 should be John Randolph Lindsay Iva B. Harrell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a Randolph H. Lindsay/ Son Eastgate Court. Owings Mills, Maryland 21117 other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May Pate ò 1 Burial 2 X Cremation 3 Removal from State Department o Important: If any injury or Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Metro Cremat<u>ory,Inc</u> Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) schemic Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) Month Pregnant at time of death Day Year Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director; After this certifics completed filled in by the funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 1 No Other: 1 Tes Certificate: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifie 29c. License number 20066515 29 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cedar Lane, Columbia, Maryland 21044 31. Date filed (Month, Day, Year) 82. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

10-03200	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Mavi Moreno Maldonado Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death Decedent's Name (First, Middle,Last)
Mavi Del Socorro Maldonado Moreno Physician/ 1643 hrs Medical Examiner April 25, 2010 MAVI MORENO MALDONADO 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore University Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director Country) MEXICO 1 M 2XF 1992 17 NOV. n/a Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Ę 10a. State 10b. County 1 X Yes 2 No 28a-f show BALTIMORE Pages 1 and 2 should be filed within 72 hours after death with the Maryland unent of Health and Mental Hygiene. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3232 E. 21224 MEXICO BALTIMORE STFuneral 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 X Married 1 Yes 3 Widowed f Yes, Give Yeer 1 X Yes 2 No specify: MEXICAN Specify: WHITE 4 Divorced Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner. ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) MD 21215-0036 DAYCARE PROVIDER DAYCARE 12TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HERMINIA MORENO RAMIRO MALDONADO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20708 11217 BASSWOOD, LAUREL, MD MELINDA CASSETTA/FRIEND 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 X Removal from State <u>RANCHERIA TEIRRA BLANC 05/12/2010 TRIANITARIA CHAPAS</u> 4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 21231 2007-09 EASTERN AVE., BALTIMORE, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Physician Between Onset and /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or es a consequence of): Sequentially list conditions. Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit by Physician/Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. attending physician for use as the burial Division of Vital Records, P.O. Box 68760, has been signed by the 2 should be detached for certificate this After within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Completed

Be

Certification

Medical

one)

25 Was case referred to medical

2 No

5 Pending

Name and address of person who completed caus

Investigation

Could not be

determined

examiner?

1 Natural

2 Accident

1 Yes

27. Manner of Death

Suicide

Homicide 29a. Certifier 1

29b. Signature and title of certifier

Theodore M. King, Jr., MD.

c					
UNPENDED	X AMENDED #1. per ME G903 5/19/10 TT				
F FEMALE:	23c, If yes, outcome of pregnancy		23d. Date of de	ivery	
3b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ✔ Unknow	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown		Month	Day	Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	cco use contribut	e to the cau	se of death?
		1 Yes	2 No 3	Probably 4	4 Unknown
		24a. Was an autopsy performe 1 ✔ Yes 2	prio dea	r to completi	ndings available ion of cause of

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

31. Date filed (Month, Day, Year) **AY 0 5 2010** 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

111 Penn Street, Baltimore, MD 21201

OCME

26.Place of Death (Check only one)

28c. Injury at Work?

29c. License number

O.C.M.E.

1 Yes 2 ✔ No

Other Nursing Home 5 Residence 6 Other

28d. Describe how injury occurred

Subject pedestrian struck by motor vehicle

or Town, State) Philadelphia Road and Petrie Way, Rosedale, MD

April 26, 2010

28f. Location (Street and Number or Rural Route Number, City

29d. Date signed (Month, Day, Year)

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc.

1600 hrs

Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3 DOA

28a. Date of Injury

and manner stated.

Apr 25, 2010

(Specify) Local Street

Assistant Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Wayne McDaniel Month 3:35 1 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 818 S. LUZERNE AVE BALTIMORE Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Birthpia Country) MD 1 XM 2 - F Hours DEC. 17, 1955 Director 213-70-3013 54 Usual Residence of Decedent 28a-f shov 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 818 S. LUZERNE AVE 21224 USA Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 1 ☐ Yes 2 🗷 No If Yes, Give Black, White, etc. 1 X Never Married 2 Married \$ Baltimore, Maryland 21215-0036 WHITE 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12TH LABORER WAREHOUSE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be file trrent of Health and Mental rtant: If item 27 is marked o ပ WALTER McDANIEL, JR. MARIE GORSKI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARTHUR MCDANIEL/BROTHER DUNDALK. KAVANAUGH RD., or other MD20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/21/2010 ARDENT HANOVER, MD 21. Signature of Funer Service Scenses 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 2007-09 EASTERN AVE., BALTIMORE, MD 23a. Part 1. Enter the disease, complications that caused shock, or heart failure. List only one cause on each line. ne death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician/ Cancer of disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician a d be detached for use as the burialby Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burn Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy
5 Other (specify) Month Yea Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical B B 26. Place of Death (Check only one) examiner? 2 No မ 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner To the best of my knowledge, death occurred at the time, data and place, and due to the cauce(c) and marker as state 29b. Signature and title of certifier

MSRAMPUNE MD 29c. License number 29d. Date signed (Month, Day, Year) DO057465 4128/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

23. Name and address of person who completed cause of death (Item 23a) (Type, Print)

23. Name and address of person who completed cause of death (Item 23a) (Type, Print)

23. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year,

0 5 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month O ZO10 **Physician** KAMAIAH ARIEL 2333 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTIMORE BALTIMORECITY UNIVERSITY OF MARYLAND MED CER If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, OL 29 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 2010 MARYL Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ms 23a or 28a-f shound at the notified at 1 ☐ Yes 2 ☐ No Director moz 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 2 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 6 Items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Item any Injury or other traumatic event, It. Modical Evantion once. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐Yes 2 ☐ If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 1 □Yes 2 No ack <u>ک</u> Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be IMO 19b. Mailing Address (Street and Number or Rural R te Number, City or Town, 19a. Informant's Name elationship (Type. Print) rittani 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Gremation 3 Removal from State 5 ☐ Other (Specify) 4 Donation 21. Signature Fineral Service Licens 4682 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** EXTREME PREMATURIT disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner TURE OF MEMBRANES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2000No certificate 1 ☐Yes 2 ☐No 1 ☐Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, it 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1∐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

DHMH 17 Rev 1/2001

State Registrar 22 SQUEENE STREET, BALTIMORE MD 2120

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAYHBLANGHARD

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTEM# 20a-c&22perFH, G903, 5/11/2010, WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician Mary Jane Martin 1925 28,2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Salisbury Rehabilitation + Nursing Cts. 5. Social Security Number 6. Sex 7. Age (In yrs. lastoirthday) alisbur If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 □ M 2 🖺 F Months 220-28-0804 76 1934 Delaware Director March 1, Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinet must be notified at once. MD Wicomico Salisbury 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1109 Fairground Drive; Apt 4 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 21215-0036 Specify: White 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk clerk convenience store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Rensy Morgan ల 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ray Bratten/son 7730 Pittsville Road; Pittsville, Maryland 21850 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Cremation 3 ☐ Removal from State Final Journey Crematory 5/10/10 Woodbine, MD 22. Name and Address of Facility Maryland Cremation Services
State Anatomy Board of Cremation Services
TV POX 1413 Martimore, MD. 21203 reral Service Licer Ona L 21. Signature Wade 23a. Part 1. Enter the disease, or complications that used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of ch line. Approximate Interval Between Onset and Death **Physician** 02 years disease or condition resulting in death) /Medical Due to pr a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physiclan and d be detached for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 Other (specify) ☐Yes 2 ☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u></u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 2 100 Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပို 27. Manner of eath 1 currural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) nd manner states 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200 William H. Robins M.D 21804 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deatl 3. Time of Death Physician/ 35 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Northwest Hospital Randallstown Baltimore . Sex 1 X M 2 □ F Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD Days 219-44-5020 Hours Min. 01/06/1945 65 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Sant: If item 27 is marked other than "natural", or items 23a or 28a-1 sho, ury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21214 Funeral 5913 Theodore Ave. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian. Armed Forces?
1 X Yes 2 □ No Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give 1964–1970 Year or Dates. Specify: White 3 Widowed 4X Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore Police Officer Law Enforcement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Angelina Lazzera Joseph John Mantegna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Mantegna / Daughter 533 S. Belnord Ave., Baltimore, MD 21224 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State Most Holy Redeemer 05/08/2010 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Bailey Funeral Home and Cremation Service, PA Mul & M01452 4023 Annapolis Road, Halethorpe, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pere bral Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy signed by the atter in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably been s page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, t 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Spec Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work' 1 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the caus Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number mi and address of person completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year,

			Please	Type or Print in B AMEND ITEM#171 State of Maryland	lack in perFH, / Depa	delible Ink G903,5/5 rtment of F	. Ensure / /2010 WS lealth and h	All Copies Mental Hyg	Are Legibl	e.
			For State Registrar			ificate of E			eg. No.	J 14UZ4
	Physicia Medic		1. Decedent's Name (First) Middle, Last,	her MA	e	Mae	loy	2. Date of Death Month	Day Yea	3. Time of Death
	Examin		4a. Facility Name (if not institution, give s	Road	10	Battimos	Location of Death		4c. County of D	
	Funeral Director	3	5. Social Security Number 6. Sept. 1 December 1 Decemb	7. Age (In yrs. last	Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, HUGUST o	Year) 1930 N	Birthplace (State or Foreign Country) Reff GRolina
	ryland -f show ied at	ctor	10a, State 10b. County	4	Town or Loc			,		10d. Inside City Limits 1 Yes 2 □ No
	the May or 28a e notifi	Director	THEY And Number	<u> </u>	MORE	10f. Zip Code	<u> </u>	1	l0g. Citizen of What	
	th with ns 23a must b	Funeral	1220 Bloomingdo			2/21			USA	
36	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces?1 ☐ Yes 2 🗷 No If Yes, Give	lf lf	as Decedent of Hi Yes, specify Cuba ☐ Yes 2 🕬 No	spanic Origin? (Sp n, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)	merican Indian, hite, etc.	
2-00	natura dical E	plete	15. Decedent's Ed (Specify only highest grad		16a. Decede	ent's Usual Occupa	ation Juring most of work	dina I	16b. Kind of susine	ess Industry
21215-0036	within 72 ygiene. her than '	e Completed	Elementary/Seconday (0-12)	College (1-4 or 5+)	Chile. DC	NOT use retired)	٤		own the	ome
Maryland	be filec ental H ked ot ic even	To B	17. Father's Name (First, Middle, Last) Marvin Leon, Neal Mes				18. Mother's Nam	ne (First, Middle, N Thom f		
lary	should and M is mar aumat		19a. Informant's Name/Relationship (Typ	-	19b. Mailing	g Address (Street a		al Route Number,	City or Town, State,	4
-	and 2 Health tem 27 other tr		JAMES A. Malloy 20a. Method of Disposition	20b. Pla	.ce of Dispos	Sloom ition (Name of	ingdale		20c. Location - City	md. 3/3/6 or Town, State
Baltimore	age ent c ent c y or		1 Burial 2 Cremation 3 4 Onation 5 Other (Specify	Removal from State cer	n] Z	atory or other plac	MAY	8,2010	Lansdown	JE MARYLAND
Balt	permit. Page Department o Important: If any injury or once.		21. Salature of Funeral Service License	ee Handon	22. Uh	Name and Address	S of Facility UAIIACE	CuneRAL	SERVIL	PARULAND 21229
	nysician/ Medical Examiner		23a. Part 1. Enter the disease, or comp shock, or heart fature. List only on immediate Cause (Final disease or condition resulting in death)		Do not enter			or respiratory arre		Approximate Interval Between Orbst and Death
§. ∂.	nath certificate be executed attending physician and for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	b. Due to (or as a conseque Due to (or as a conseque d.						
Box 68760	e death certificate be the attending physic hed for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 9	23c. If yes, outcome of pregnand 1 ☐ Live Birth 2 ☐ Fetal of the lime of de 9 ☐ Unknown	death 3 🗌	Ectopic pregnand Other (specify)	у		23d. Date of Month	delivery Day Year
s, P.O.	law requires that the der has been signed by the a e 2 should be detached	2	Part II. Other significant conditions co	ntributing to death but not resul	ting in the ur	nderlying cause giv	en in Part I.	12		e to the cause of death?
Division of Vital Records,	Attending Physician: The law requires or dreath. The third sentificate has been sign of the funeral director, page 2 should be	Completed						24a. Was ai autops perforr	sy prior deat	
a B	ilcian: The certificate rector, pag	Be Co	25. Was case referred to cal examiner?				ace of Death (Chec	1 - 100	2 16 1 1	Yes 2 No
Ž	nding Physician: th. : After this certifics : funeral director, p	မ	1 ☐ Yes 2	lospital: 1 Inpatient 2 E 28a. Date of injury 2	R/Outpatien	3 DOA Othe	4 □ Nursing H		ence 6 Other (S	pecify)
ouo	ending sath. or: After ne fune	Certificate:	atural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	work		200. 2000/120 110	www.mjary occurred	
Divisi	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (St. City or Town		Rural Route Number,
	Hospi 24 hou Funer leted fill	Medical	(Check 2 Medical Examir	ician: To the best of my knowled ner: On the basis of examination a e Practioner; to the lest of my k	and/or investi	gation, in my opinio	on, death occurred a	at the time, date an	d place, and due to t	the cause(s) and manner stated.
	To the within To the compl	Σ	only one) 3 Certifying Nurse	I laurispiet y lo trie pest of my R	owieuge, a	29c, License			29d. Date signed (M	
				1000	00a) (Ti = - D	J) Ø	10110 PO WIER	8J	d Greent	20/0
	3		00/	Simpleted cause of death (Item 2		2256	reasest	-, Baltim	ce MD 2	12×1
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	iarle	•				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) May 2, Year 201₀ Robert J. McLaurine 9:10 am 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore 8800 Walther Blvd. Apt. 2006 Parkville If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) September 30 1923 Days Hours 1 € M 2 □ F 86 Yrs. Baltimore City, MD 218-18-7590 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 🙀 No Baltimore Baltimore County Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21234 8800 Walther Blvd. Apt. 2006 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. If Yes, Give Year or Dates: WW II Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Painting Co. 12 Owner 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna Fehr John Edward McLaurine 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Yvonne McLaurine (wife) 8800 Walther Blvd. Apt. 2006 Baltimore, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State May 3, 2010 Baltimore, Maryland Metro Crematory 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Lassahn Funeral Home 7401 Belair Road Baltimore, Maryland 21236 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 D Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 1 □ Yes 2 🗌 No 4 Unknown arsease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran as page 2 should be has certificate

Physician

Examiner

Funeral

Director

show

Directo

Funeral

Completed by

Be

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Examiner

by Physician/Medical

Completed

Certification: To Be

Medical

29a. Certifier

item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Modical Examiner must be notified at

is marked other than

Department of Heal Important; If item 2 any Injury or other once.

Physician /Medical

Examiner

death with the Maryland

filed within 72 hours after

should be

Pages 1 and 2 Health a

permit.

Baltimore,

land 21215-0036

MCLOURING

/Medical

Division of Vital Records, P.O. Box 68760, To the Hospital or now.

Within 24 hours after death.

To the Funeral Director: After this certified to by the funeral director.

State Registrar

29b. Signature and title of certifier

and manner stated

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License numbe

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brusha Dixon 8200 Walther

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For
State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2:32 P_M May 2010 Year 4, Mary Edna Mueller-Knott Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Baltimore Timonium 8. Date of Birth (Month, Day Yea Dec . 25, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □**X** Hours Maryland 217-38-1779 69 1941 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits death with the Maryland Director MD Howard Columbia 1 Yes 2 X No 10f. Zip Code 0e. Street and Number 10g. Citizen of What Country? Funeral 9277 Cartersville Road 21046 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinone. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: white Specify: 3 XWidowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Shelter Properties 12 Property Management Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William G. Dibbern Margaret McCarthy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21046Steve Mueller-son 9277 Cartersville Road-Columbia, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evans Funeral Chapel and Forest Hill, Maryland Cremation Services Pelair May 6, 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral ondrae 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ LUNG DISEASE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Due to for as a nonsequence of: ending physician and use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be ex by Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 9 Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? the Funeral Director: After this certificate has been signed in pleted filled in by the funeral director, page 2 should be det Completed 1 \square Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 **X** No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

MUELLER-KNOTT

State Registrar

le

(Check only one)

29b. Signature and tit

JACKÍE JONES,

2300 DULANEY VALLEY RD.

of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

CRNP

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

TIMONIUM, MD 21093

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MACTH 3,2010 5:15 ANNA MARSHALL ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GILCHRIST CENTER FOR HOSPICE BALTIMORE TOWSON 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral 1 D M 2 DX Months Davs Hours Min. OCT. 1918 MARYLAND 213-09-5040 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 ☐ No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3112 Mcelderry Street 21205 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give 1 ☐ Yes 2X No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha HOUSEWIFE DOMESTIC 9 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည LOUIS SMITH MATILDA N/A 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sl
Department of Health al
Important: If item 27 is
any injury or other PATRICIA BILLINGS/DAUGHTER 3112 McELDERRY STREET, BALTIMORE, MD. Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 🐰 Burial 2 □ Cremation 3 □ Removal from State 5/5/10 GARDENS OF FAITH BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee LY ACTOS ÉTER INC. FUNERAL HOME 1 EASTERN AVENUE, BALTIMORE, MD 21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) meristand Physician/ breast monta Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last physician are the burial-t Physician/Medical death certificate be attending pl for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 W No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🗆 Yes 2 🗆 No 3 🗆 Probably 4 📈 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Hospital or Attending Physician: 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 MOther (Specify) No spud 2 No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of **Certificate:** 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No 2/ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier \overline Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one

State Registrar

29b. Signature

31. Date filed (Month,

Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HANVES

32. Registrar's

6701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🤈 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10:25 AM Nicholas A. Nizer, Jr 2010 01 MAY Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SAINT JOSEPH MEDICAL CENTER TOWSON BALTIMORE 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 220-18-6229 1 🔀 M 2 🗆 F Months Days Hours Min. Aug. 7, 1924 Maryland Director 85 Usual Residence of Decedent 3a or 28a-f shov t be notified at 10a. State filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Baltimore 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA 21206 ral", or items 23 Examiner must 5515 Daybreak Terrace items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Force Black, White, etc. 1 Yes 2 No 2 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white 3 Divorced Completed Year or Dates ed other than "natur event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) City Finance Elementary/Seconday (0-12) College (1-4 or 5+) Financial Manager Be 18. Mother's Name (First, Middle, Maiden Surname)
Louise Rhinehart 17. Father's Name (First, Middle, Last) Nicholas A.Nizer Sr Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5515 Daybreak Terrace-Baltimore, Maryland Anna C. Nizer-spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Gardens Of Faith Cemetery permit. Page Department May 6,2010 Rosedale, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel and Cremation Services
8800 Harford Road-Parkville, Maryland 21234 Condrale 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ NON HODGKINS LYMPHOMA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner RESPIRATORY WOCK Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): attending physician and for use as the burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atter in the past 12 months? Dav 5 Other (specify) Pregnant at time of death 1 Yes 2 No a Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician: The law requires 2 No cate has been sig page 2 should b 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy death? Yes 2 No ours after death. eral Director: After this certifica filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3
Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours at Euneral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) lo adle Mo 05-03-10 D0059711

V

State Registrar OSLER

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DRIVE

TOWSON MARYLAND

21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

m.D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NEWBERGER 2:50 PM NILLIAM APRIL 2010 Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NORTHWEST BALTIMORE RANDALLSTOWN . Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 56 Months Days Hours Min. (Month, Day, Year) Maryland 214-70-7614 Director 1954 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location event, the Medical Examiner must be notified at 10d. Inside City Limits Director 28a-f MD 1 Yes 2 No Baltimore Catonsville 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? Funeral death with 23a 21228 4131 Balmoral Circle United States items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married ō 72 hours after 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: "natural" 3 Divorced Completed White Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) N/A N/A Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Christopher George Newberger Dorothy Loretta Sarsitis injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Mary E. Newberger /Sister 2117 Oak Lodge Road Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of May 01 20c. Location - City or Town, State Department of I Important: If it any injury or of once. cemetery, crematory or other place 1 Burial 2 K Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland 2010 Chesapeake Crematory 21. Signature of Funeral Service Licensee 22. National Alternatives Rebecca MG158 Hockey 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. nterval Retween Onset and Death Immediate Cause (Final Physician/ 0 disease or condition Medical resulting in death) Examiner 04) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to lor as a consequence on Examir Cause (Disease or linjury that initiated events physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical certificate be Box 68760 the attending p IE FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Dav 2 🗆 No the 9 Unknown signed by the Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ. Menta. etandation Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? page After this certificate 1 Yes 2 No 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 2 No 1 Yes ည 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 \sum Yes 2 \sum No Natural 5 Pending iniury death. 2 Accident
3 Suicide Investigation within 24 hours after death

To the Funeral Director:

completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse yradioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29c. License numbe 29d. Date signed (Month, Day, Year) MPRIL 28, 2010 D0060293 rson who completed cause of death (Item 23a) (Type, Print) M.D. COULT ROAD 5401

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Barry Oakes May 2010 2:20 PM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 7200 Third Avenue Apt M418 Sykesville Carroll Birthplace (State or Foreign Country)
 New York If Under 1 Year If Under 24 Hrs. Social Security Number 8 Date of Birth **Funeral** 7. Age (In vrs. last birthday) Days (Month, Day, Year) an 21, 1928 Min 1 🔀 M 2 🗆 F Director 111-24-6629 82 Jan Usual Residence of Deceden iral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7200 Third Avenue Apt M418 21784 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 ☐ Never Married 2 🙀 Married þ 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: "natural", Specify: 3 Widowed 4 Divorced Completed White the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Johns Hopkins Applied Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Electrical Engineer Physics Lab Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental F is marked ot other traumatic Leonard Bertram Eloise Vaughan Barry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl it of Health a: If item 27 i Lois B. Oakes/wife 7200 Third Avenue Apt M418 Sykesville, MD 21784 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 5/5/2010 Woodbine, Maryland 21. Sign ture of Funeral Service Lice Goling in Address of Facility attion Service P.O. Box 784 M00957 Beverly L. Heckrotte, P.A. Clarksville, Homan 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Acute Myelogenous Leukemia 6 months Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami that the death certificate be executed burial-transit and Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death 2 No signed by the a d be detached t 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, the Hospital or Attending Physician: The law requires Metastatic Prostate Cancer 2 XNo 3 ☐ Probably 4 ☐ Unknown been signature Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Disseminated Aspergillosis cate has by page 2 s autopsy performed? certificate I 1 Yes 2 No Yes 2X No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 2 🔀 No ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After t Certificate: 5 Pending 1 X Natural work? 1 🔲 Yes ☐ Accident ☐ Suicide Investigation within 24 hours after deatl

To the Funeral Director:,
completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. Judith E. Karp, 1650 Orleans St CRB 1 Rm 2M44 Baltimore, Maryland 21287

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

*2*010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 6 per ab g903 5-5-10 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Bay 2010 **Physician** Arnold Rae Post 11:43 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sandy Spring

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 17310 Quaker Lane #C-9 Montgomery 5. 906 Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 □ F -0006-14-8977 87 Dec 26, 1922 Director Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at MD Montgomery Sandy Spring 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 17310 Quaker Lane: C-9

Marital Status

| 12, Was Decedent Ever in U.S. Armed Forces? |
| 1 Never Married | 2 Married | 12 No | 1942 - |
| 1 Yes, Give | Year or Dates: | 1945 |
| 167 within 72 hours after death with USA Funeral 20860 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Baltimore, Maryland 21215-0036 Specify: white 1 □Yes 2 No Specify. Completed by 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Secondary (0-12) city planner state of Pennsylvania 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Levi Arnold Post Grace Lickely 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna E. Post/spouse 17310 Quaker Lane; C-9; Sandy Spring, MD 20860 20b Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of I Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature 22. Name and Address of Facility Board; 655 W. Baltimore Street Ronal . Wade Baltimore, Maryland 21201 Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1 Immediate Cau (Final disease or condit resulting in death) Metastatic **Physician** lung Lances /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Director for as a consequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed 1 ☐ Yes 2 Mo After this certification 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Man or of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural Injury 24 hours after death.

Funeral Director: A 1 ☐Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 23, 2010 exoffunds 039793

State Registrar 31. Date filed (Month

MAY 0 5 2010

32. Rastrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print).

Christey, has I. Mays, mis 18111 Prince Philip Dr. elney, mo 20832

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 16032 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** April 2016 7:45 Рм Gretchen Proos Grethen Lorenz Proos /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wilson Heath Care Center Gaithersburg Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Days Hours Min. Nov 21, 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 1 □ M 2 🛣 F Ohio 99 213-40-8610 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Gaithersburg Montgomery Funeral Director 1 □Yes 2X□No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 432s407 Russell Avenue; #110 20877 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No þ Specify: White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 teacher education 17. Father's Name (First, Middle, Last)

Kumler

Karl Kermler Lorenz 18. Mother's Name (First, Middle, Maiden Surname) Be Carolina Bell Boalt ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Zehring/daughter 3567 17th St; San Francisco, California 94110 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 XDonation 5 ☐ Other (Specify) 21. Signature of uneral Service Icensee 22. Name and Address of Facility Board; 655 W. Baltimore Street 23a. Part 1 Enter the disease, or com shock or heart failure. List only Immediate Ca. (Final disease or condition resulting in death) Director Baltimore, Maryland 21201 , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death one cause on each line Acute coronary Due to (or as a consequence of): ryas Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 🔲 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ pertension Tricuspid 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown mpleted 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed2 nher.

Division of Vital Records, P.O. Box 68760,

Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit certificate has : After this certifica e funeral director, p Hospital or Attending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Funeral

Director

28a-f show

ral", or items 23a or 28a-f shov Everal per past be notified at

"natural",

item 27 is marked other than "natur other traumatic event, the Medical

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau

Physician /Medical

Examiner

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

BeC	25. Was cas referred to medical	in. compres	ains	1	ath (Check only	2 No 1 Yes 2 No	
To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp	oatient 3 DO	Othori		sidence 6 Other (Specify)	
Certification:	27. Manner of Death 1 Matural 2 Accident investigation 3 Suicide 6 Could not be		ury M	3c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route		
Certil	4 ☐ Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	i, street, lactory,	onice	City or To	wn, State)	
Medical	29a. Certifier 1 ✓ Certifying Ph (Check only one) 2 ☐ Medical Exam	ysician: To the best of my knowledge, on the basis of examination and/and manner stated.	at the time, date and place in my opinion, death occ	e, and due to the urred at the time	e cause(s) and manner as stated. , date and place, and due to the cause(
Ž	29b. Signature and title of certifier		29c	License number		29d. Date signed (Month, Day, Year)	
	H. Rohest Bu	ischbachus	N Car	04115		4xil 28,2016	
	30. Name and address of person who described the second se	completed cause of death (Item 23a) (Ty BIKSCHBACH, M	ype, Print)	OI RUSSI AITHERS	BURG	NU ZOSAY	
e ir	31. Date filed (Month, Day, Year) MAY 0.5.2	32. Registrar's Signature	hash	P			
01		,	7				
			ORIGINAL				

Sta Registr Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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		Registrar 1. Decedent's Name (First, Middle, Last)		007	anoato or E	, out 17	1		3. Time of Death
Physiciar Medic		Gracine Pho	295				2. Date of Dea	30 Year	6:47 PM
Examine	er	4a. Facility Name (if not institution, give street and	number)			Location of Death	∞	4c. County of De	ath
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthdav)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h 9. E	Sirthplace (State or Foreign
Director	- 1	219-62-3017		Yrs.	Months Days	Hours Min.	Mar. 12	952 Mai	ryTand
d t tow		Usual Residence of Decedent 10a. State 10b. County	10c City	Town or Loc	ation				10d. Inside City Limits
arylar a-fsh ified	읂	Maryland Harford			sville				1 ☐ Yes 2 🙀 No
the M or 28	₫	10e. Street and Number		arrect	10f. Zip Code			10g. Citizen of What	
n with	Funeral Director	1750 Jumpers Court			21084		į.	Inited Stat	es
or item		Armed	Decedent Ever in U.S. d Forces? ∕es 2 ፟፟፟፟ 2 No	13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	nerican Indian, iite, etc.
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exam	Completed by	If Yes,	Give or Dates.	1	☐ Yes 2 🙀 No	Specify:		Specify: Wh	nite
15-(nple	15. Decedent's Education (Specify only highest grade comple	ted)	(Give k	ent's Usual Occupa kind of work done of NOT use retired)		king	16b. Kind of Busines	s Industry
vithin jiene.		Elementary/Seconday (0-12) Colleg	e (1-4 or 5+)		stylist			Beauty Sa	alon
filed v al Hyg d othe	Be	17. Father's Name (First, Middle, Last)	•					Maiden Surname)	-
Vla	잍	Alberico Lamasa					s Gentil		
		19a. Informant's Name/Relationship (Type, Print) Richard J. Phelps / Hu	ısband					; City or Town, State, I lle, Mary	
Saltimore, bernit. Page 1 and Department of Hee Important: If item any injury or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal f	20b. Pla rom State F.V.A	ace of Dispos metery, crem	sition (Name of natory or other plac neral Cha	nel May		20c. Location - City	· -
nit. Pa artmer artmer ortant injury		4 Donation 5 Other (Specify) 21. Signatury 1 Funeral Service Licensee	l B	el Air	Name and Addres	s of Eacility			l, Maryland
Departing any ince.		> pullbux		E7	vans Fune Newport	ral Chap Drive Fo	el & Cre rest Hil	mation Ser 1, Marylar	rvice-BelAir nd 21050
		23a. Part 1. Enter the disease, or complications to shock, or heart failure. List only one cause of	at caused the death. n each line.	Do not ente			or respiratory arr	est,	Approximate Interval Between
Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	to (or as a conseque	DC.	Cance	el			Onset and Death
Examiner			to for as a conseque	ance on.					
pe psit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	to for as a conseque	ince of,					
ords, P.O. Box 68/60 requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Exa	that initiated events c	to (or as a conseque	ence of):					
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the de ached	hysi	9 Unknown 9 U	Jnknown						
s that the igned by be detac	ا ۾	Part II. Other significant conditions contributing	to death but not resu	Iting in the u	nderlying cause giv	en in Part I.			to the cause of death? Probably 4 Unknown
rdS require	eted 								autopsy findings available
VITAI KECOTGS, ysician: The law requires is certificate has been sig director, page 2 should b	Completed						24a. Was autop perfo	sy prior t med? death	o completion of cause of ?
an: Th tifficate tor, pa	Be C	25. Was case referred to medical		-	26. Pla	ace of Death (Chec	1 Yes	2-□ No 1 □ Y	′es 2 □ No
VITA nysicia	일		☐ Inpatient 2 ☐ E	R/Outpatien	t 3 🗆 DOA Othe	er: 4 Nursing H	ome 5 🗆 Resid	ence 6 Other (Sp	ecify) MODICO
n or ding Ph n. After th funeral		1 ☐ Natural 5 ☐ Pending	ate of injury Month, Day, Year)	28b. Time of injury	28c. Injury work M 1 🗆	∕at ? Yes 2 □ No	28d. Describe h	ow injury occurred	
DIVISION lal or Attendir s after death. al Director: After fur	Certificate:		ace of Injury - At hon	ne, farm, stre		169 5 140		treet and Number or F	Rural Route Number,
ital or all car all bird in led in		Di	uilding, etc. (Specify)			4	City or Tow	n, State)	
DIVISION OF VITAI RECORDS, P.O. BOX 68/60 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the Certifying Physician: To the Certifying Nurse Praction	basis of examination	and/or invest	igation, in my opinio	n, death occurred a	at the time, date a	nd place, and due to th	e cause(s) and manner stated.
To th Within To th comp		29b. Signature and title of certifier	11-0	0	29c. License	number		29d. Date signed (Moi	nth, Day, Year)
		Jenny u la	V CHU			7629		2/1/20	0/0
10		30. Name and address of person who completed Jennifer Hauf, CRNP (23)	guse of death (Item 2 300 Dulane			imouni	MD 212	02	
State	_	31. Date filed (Month, Day, Year) 3	2. Registrar's Signatu	re		TUCULLUM	<u> </u>		
Registra	r	MAY 0 5 2010	Viewa &	ba	A SOL				

10-03388 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jeremy Lee Parker State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Rea. No Registrar Physician/ Decedent's Name (First Middle Last) 2 Date of Death Jeremy Lee Parker Month Day 0440 hrs Medical Examiner May 3, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2906 Hillcrest Avenue Parkville **Baltimore County** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or Foreign **Funeral** Country 199-36-4867 Davs Min. Months Hours Jan. 30, 1948 Director 62 North Carolina 1Х м 2 Usual Residence of Decedent any 10d. Inside City Limits Oc. City. Town or Location 10a State 10b County MD Baltimore Parkville 1 Yes 2 X No 23a or 28a-f show notified at once. 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 2906 Hillcrest Avenue 21234 U.S.A. Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, or items Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 X Married Never Married 2 X No Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: White Specify: à 16a Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Packaging d other than ' Industrial Design 21215-0036 12 4 17 Father's Name (First Middle Last) 18 Mother's Name (First Middle Maiden Sumame) Genevieve Hopman James Jarvis Parker 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 2906 Hillcrest Avenue, Baltimore, Maryland 21234 Jane Parker- Wife item 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Evantsy of the place)1 Pages 1 May 2010 4, Forest Hill, MD 4 Donation 5 Other Specify Chapel-Bel Air 22. Name and Address of Facility Evans Funeral Chapel & Cremation Servi 8800 Harford Rd. Parkville, Maryland 2 i nature of Funeral Service Licens Part I. Er fer the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease aminer condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. ner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and transit Physician/Medical attending physician or use as the burial UNPENDED AMENDED The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death Live birth 3 Ectopic pregnancy Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown for 9 Unknown the has been signed by the 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available certificate has been prior to completion of cause of autopsy death? page Yes 2 ✔ No 1 Yes 2 No Hospital or Attending Physician: director, 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: Other Nursing Home 5 Residence 6 🗹 Other Scene DOA this Inpatient 2 ER/Outpatient 3 1 🗸 Yes No After 28a. Date of Injury (Month, Day, Year) . Manner of Death 28b. Time of Injury 28c. Injury at Work 28d. Describe how injury occurred Certification: 1 🗸 Natural Pending 1 Yes 2 No 24 hours after death.

Funeral Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal within 2 To the 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) tþe and manner stated. 29h Signatule and title of certifier 29c License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 3, 2010 ress of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year, 32. Registrar's Signatur State Registra

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Please Type or Print in Black Indelible Indeli State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MAY Physician/ POPKIN 2010 8:14 A M ALICE Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE 7237 GUNPOWDER ROAD MIDDLE RIVER 9. Birthplace (State or Foreign Country) CANADA 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 🗆 M 2 🕅 F Hours 6/15/1928 578-42-4942 83 Director Usual Residence of Decedent Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director **MONTGOMERY** 1 Yes 2 No MD OLNEY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20832 USA 18534 MEADOWLAND TERRACE 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? 1 ☐ Yes 2 ☐ No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No WHITE Specify: If Yes, Give Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) FREELANCE JOURNALIST **JOURNALISM** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ROSENSWEIG LIBBY ABINOVITCH SAMUEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DARREN POPKIN/SON 18534 MEADOWLAND TERRACE, OLNEY, MD 20832 20a. Method of Disposition
1 A Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of celled by Alma My Molecular) 20c. Location - City or Town, State **GARDENS** 5/4/2010 OLNEY, MD ■ Sonation 5 ☐ Other (Specify) Signature of Funeral Service Lice $^{22.\,Name\ and\ Address\ of\ Facility}$ SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 22. Name and Address of Facility INC. 21208 Part 1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Alzhumurs Physician disease or condition resulting in death) 4001 Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or). Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 N 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 1 director, 25. Was case referred to edical Be 26. Place of Death (Check only one) daughter s examiner? Other: 2 🔛 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 🗆 Nursing Home Certificate: To 6 ☑ Other (Specify) residence completed filled in by the funeral 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 atural 1 Tyes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in this openion, ueath occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 3 29b. Signature 29c. License number 3,2010 NO 057169 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MONIM 15. 1467 31. Date filed (Month, Day, Year) 32. Regis State 0 5 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** Pierce M. Betty 04 28 2010 2:07p /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Keswick Nursing Home Baltimore If Under 1 Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Dav. Year) **Funeral** Days 1 □ M 2√2 F Yrs. Director 219-30-6046 04 MD Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location r 28a-f show notified at show 1 Yes 2 No Director Baltimore MD NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be i U.S.A. 28 West 27th Street 21218 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Black 3√ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12th grade na Domestic Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unknown Be ဥ Gertrude Forrester 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health a Department of Health Important: If item 27 any injury or other tr once. 6001 Greene Street, Philadelphia, PA 19144
of Disposition (Name of Date 20c. Location - City or Town, State Melody Forrester-Cousin
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages ' 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Bonation 5 ☐ Other (Specify) King Memorial Park 5/10/2010 Woodlawn, Md 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service License 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. E er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line. dia BETES mellitus Type Two immediate vause (Final di Pase o condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Uncertaing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Vital Records, P.O. 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? & ISEASE PURIPHUAL Vascul No 3 Probably 4 Unknown 1 TYes Completed VALCULAN 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ 100 24a Was an MY DEV TENSION 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To Division or 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hour. Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print)

11/1/1/1/1/2014 Balhmon W 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 20131N30N COTTON APRI2 20,2 4260AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day) 9 Birthplace (State or Foreign Country) If Under 1 Year Social Security Number 6 Sex Funeral Days 1 □ M 2 🛛 F Director Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Completed by Funeral Director 1 XYes 2 No mor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Page 1 and 2 should be filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces?, 1 ☐ Yes 2 🕅 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ 19a. Informant's Name/Relationship (Type, Print) (Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Home Jean 23a. Part 1 Inter ye disease, / complications that clused t shock, or he if failure. List only one cause on each line. complications that a used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final 559515 Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ACQUIRED IMMUND DEFICIENCY Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury RIERIUSCZEROTIL HEART DISEASE ng physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 the attending posterior that the IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy ☐ Pregnant at time of death 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ HYPERTENTION 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an has autopsy performed' death? Yes 2 No 2 🗌 No Division of Vital completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work?
1 Yes 2 No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Director: After 1 Natural
2 Accident
3 Suicide 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital of thin 24 hours af the Funeral Di Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioger: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month. Day, Year) D 23300

Registrar DHMH 17 Rev 7/2009

State

2000W, 13ALTO ST.

1710. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ろさん ろ たくしんたろ

DIPATEZ,

32 Registrar's Signature

SUDKIC.

MAY 05 2010

31. Date filed (Month, Day, Year)

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2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 2010 Francis Robert Rahl, Sr. 1:45a Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death 27 South Stricker Street Baltimore N/ASocial Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Sep. 10, 1 🙀 M 2 🗆 F Months Days Hours Min. 90 Pennsylvania Director 189-14-5689 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No N/A Maryland Baltimore 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 27 South Stricker Street 21223 United States 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ 2 🗆 No WWII Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify: White 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Railroader Railroad other t Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Jacob Andrew Rahl Harriet Eicher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francis R. Rahl, Jr./ Son 27 Stricker Street, Baltimore, Maryland 21223 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🖾 Cremation 3 🗆 Removal from State Metro Crematory, Inc. May 3, 2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facilit Cremation Society of Maryland, Inc 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) NON-SMOIL CE11 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, leaves. Enter Underlying Cause (Disease or linjury Examiner Due to lor as a consequent of use as the burial-transi or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Year 5 Other (specify) Day been signed by the should be detached 9 Unknown ■ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy cate has page 2 s performed? Yes 2X No this certificate 2 🗆 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 🔀 No Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? s after death. I Director: After t 28d. Describe how injury occurred (Month, Day, Year) 1X Natural 5 Pending 1 Yes 2 No Accident Investigation completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital of within 24 hours a To the Funeral D Medical 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifie 2010 WX1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	te of Maryland /		tificate of E		-	giene , Reg. No. (2010	14039		
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Maurice Shaffer Jr.					2. Date of Dea Month April	Day 24	2010	3. Time of Death 11:26 P M		
	Examir		4a. Facility Name (If not institution, give street at 1986 Old Elk Neck Roa	·		4b. City, Town, or Elkton	Location of Death			ounty of Death			
	Funeral Director		5. Social Security Number 6. Sex 172-34-7309 1⊠ M 2	7. Age (In yrs. last b	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Feb 5,	h	9. Birthp	olace (State or Foreign ntry) nsylvania		
	be filed within 72 hours after death with the Maryland Hygiene. 4 other than "natural" or items 23a or 28a-f show event, the Medical Examination and by modified at	Director	Usual Residence of Decedent	10c. City, Tov		ation			10g Citize	n of What Cour	0d. Inside City Limits 1 □ Yes 2 No		
	leath with	Funeral Di	1986 Old Elk Neck R	oad s Decedent Ever in U.S.	13 W	21921	enanic Orlgin? (Sp.		USA				
JU36	ral", or iten	þ	Arried 212 Married 118	led Forces? Yes 2 □ No 1962 - es, Give r or Dates: 1966	1	/as Decedent of His Yes, specify Cubar □Yes 2⊠No	Specify:	Rican, etc.)	sı	Black, White, etc. pecify: white			
21215-0036	within 72 h ene. than "natu he wediesi	Completed	15. Decedent's Education (Specify only highest grade comp Elementary/Secondary (0-12) unk Unk United the secondary (0-12)	ege (1-4or 5+)	(Give k life. D	ent's Usual Occupa ind of work done di O NOT use retired) chinist	tion uring most of worki	ng	16b. Kind	of Business/In-	_{dustry} unk		
⊆ .	ed d al	To Be Co	17. Father's Name (First, Middle, Last) Maurice Klair Shaff		ma		18. Mother's Name						
, Iviary	12s thai 7is trau		19a. Informant's Name/Relationship (Type. Prin Susan Shaffer/spous	own, State, Zip Marylar	Code) id 21921								
	of H fiter		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remova 4 ☒ Donation 5 ☐ Offier (Spedity)	Trom State	of Dispos ery, crem	ition (Name of atory or other place) C	ate	20c. Loca	tion - City or To	wn, State		
Da	permit. Pag Department Important; I any Injury o once.		21. Signature of En + Consider Consee	IVUL		state Adres Baltimore	. Marvla	nd 2120	1	altimor	e Street		
	hysician /Medical Examiner	10		That caused the death. Do e on each line. Mesoff ue to (or as a consequence	of):	r the mode of dying	յ, such as cardiac մ	y and 21201 Irdiac or respiratory arrest, Appropriately Onset	Approximate Interval Between Onset and Death				
00/00,	nincate be executed by physician and as the burial-transit	edical Examiner	Cause (Disease or injury that initiated events c	ue to (or as a consequence	,								
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,	as been signed by the 2 should be detached	ρ	Part II. Other significant conditions contribution Diabetes //	contribute to th	ne cause of death? pably 4 Unknown								
יייייייייייייייייייייייייייייייייייייי	cate has be page 2 sho	Completed						24a. Was a autop perfor		24b. Were auto prior to co death? 1 □ Yes	psy findings available mpletion of cause of 2 No		
Dhuisisian	After this certificate hi funeral director, page	To Be			utpatient Time of Injury	Other	at Nursing Ho	me 5 Resid					
DIVISION OF	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined 28e.		il Route Number,								
the Hosen	the Funer	Medical		To the best of my knowledg the basis of examination a manner stated.	e, death nd/or inve	occurred at the time estigation, in my op	e, date and place, inion, death occurr	and due to the ded at the time, d	cause(s) ar late and pl	nd manner as s ace, and due to	tated. the cause(s)		
ļ	To Cor		29b. Signature and title of certification and ti	, S MD		29c. License	number d 2332: T , EQ	2.	29d. Date s	$\frac{1}{27/a}$	Day, Year)		
				ND 126,		tugh 5	T, EQ	zton 1	ND.	2/92/			
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signature	-	-0.6							

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** A^{M} 25 9:15 2010 Charles Smith Apri1 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ceci1 Laurelwood Care Center E1kton 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 ▼ M 2 □ F Director May 14, 1939 Maryland 70 214-36-9189 Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mudical Evantment must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Ceci1 E1kton 1 □Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 100 Laurel Drive 21921 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 🖾 No Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation unk unk 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Be William A. Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2102 Williams Drive; Havre de Grace, MD 21078 Bonnie Hitchcock/niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) in State Signature of Funeral Servi 22. Name and Address of Facility
State Anatomy Board; 655 W. Baltimore Street
Baltimore, Maryland 21201 Wade? etor 222 ins that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sensis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): ending physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 2 No 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 ☐ No 1 □Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1☐Yes 2☐No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title certifier 4/27/2010 Jachder 5 mb D0023322 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 126 A. E tujh ST Eckler MD 21921. SACHDEUMO 32. Restrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death A D r 06:48 AM SUZ UNNE OV DII 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death The Johns Hopkins Hospital **Baltimore City** N/A Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 1 M 2 X 06/27/1949 217-46-8194 60 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No St. Marys St. Inigoes 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 48585 Beachville Rd. 20694 U.S.A. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 Married 1 Yes 2X No Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 4years Social Worker DSS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles В. Saxon Savannah G. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1705 N. Bentalou St., Baltimore, MD 21216 Alysha Saxon(Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ANG Crematory or other place? H 05/03/10 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Forephrodes of Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final

Physician /Medical Examiner

permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any injury or other trau

Physician

/Medical

Examiner

10a, State

MD

Director

Funeral

2

Completed

Be

2

Funeral

Director

Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hygiene. int: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

burial-trar within 24 hours a er death.

To the Funeral Director Affer this completely filled in by the funeral of Certific

Division of Vital Records, P.O. Box 68760or Attending Physician: The law requires that the death certificate be exe

gical Examiner	disease or condition resulting in death) Sequentially list conditions, if any least of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence of): b. Acute Renal Failure Cite to (or as a consequence of): c. Pulmonary Hypertension Due to (or as a consequence of): d. Chronic Obstructive Pulmonary Disease
nysician/me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1
en by P	Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 \(\subseteq \) No 3 \(\subseteq \) Probably 4 \(\subseteq \) Unknown
Comple		24a. Was an autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No
ן מ	25. Was case referred to medical examiner?	26. Place of Death (Check only one)
2	1 ☐ Yes 2 🔀 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
ation.	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	
	3 Suicide 6 Could not be determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State)

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 - Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RES-000

State Registrar

31. Date filed (Month, Day, Year)

MAY 05 20

29b. Signature and title of certifier

29a. Certifier

(check only

Medical

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Steven

HSU

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

April 30, 2010

Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

William Schmidt	1- For State Cer	rtment of Health and Mental tificate of Death	ı mygiene Reg. N	. 2010 14042						
Physician/ Medical Examine	1. Decedent's Name (First, Middle,Last) William R. Schmidt		2. Date of Death Month Day April 28, 2010	3. Time of Death 0822 hrs						
	4a. Facility Name (if not institution, give street and number) Shady Grove Hospital	4b. City, Town, or Location of D Rockville	eath	4c. County of Death Montgomery						
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. Ia	st birthday) If Under 1 Year If Under 24	4Hrs. 8. Date of Birth (MI	M/DD/YYYY) 9. Birthplace (State or Foreign Country) 1,1948 California						
any	Usual Residence of Decedent	Town or Location	1	10d. Inside City Limits						
* ,		rling		1 Yes 2 No						
th the Maryland 23a or 28a-f sho notified at once.	10e. Street and Number	10f. Zip Code		itizen of What Country?						
with the sa 23a of the sa 15 23a of the sa 15 25 of the sa 15	20856 Channel Court 11. Manital Status 12. Was Decedent Ever in U.S.	20165 S. 13. Was Decedent of Hispanic Origin?	(Specify Yes or No-	A 14. Race - American Indian, Black,						
r death with or items 23 must be no Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes, specify Cuban, Mexican, Pu	erto Rican, etc.) Columbian	White, etc.						
urs afte tural", aminer	3 Widowed 4 Divorced of Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	1 Yes 2 No specify: 16a. Decedent's Usual Occupation (Give kind		Specify: White . Kind of Business/Industry						
5-0036 led within 72 hours a trygiene. other than "naturs the Medical Exami Completed b	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use Vice President/		Satellite Communicati						
215-0036 be filed within 7 nual Hygieneked other than ent, the Medica	17. Father's Name (First, Middle, Last)	Government Servi	CES ame (First, Middle, Maide							
1215 I be file ental H arked o vent, th	Robert S. Schmidt		a Baquero							
nore, MD 21215-0036 sges I and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. It: If item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print) Candyce S. Schmidt/Wife	19b. Mailing Address (Street and Number 20856 Channel Cour lace of Disposition (Name of cemetery,	rt, Sterling,	Va. 20165						
Ore, ges l an r of Hea r If iter ther tra	20a. Method of Disposition 20b. P 1 Burial 2 X Cremation 3 Removal from State M6	c. Location - City or Town, State								
Baltimore, permit. Pages la Department of He Important: If ite injury or other ti	4 Donation 5 Other Specify: 21. Sonature of Funeral Service Licensee	remation Services 5 wne 22. Name and Address of Facility M	5/04/2010 C	Chantilly, Virginia						
	23a. Part I. Enter the disease, or implications that caused the death.	NTIE IN Maple A	Ave. Vienn	a. Va. 22180						
Physician // // // // // // // // // // // // //	failure. List only one cause on each line.			Between Onset and						
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Hypertensive a Due to (or as a consequence of)	therosclertic cardio	vascular dis	sease						
ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of)									
aminer	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last under the control of the cont	:								
and transit	d.									
50, te be execut ysician and burial - tra	AMENDED 23a,27,perm IF FEMALE: 23c. If yes, outcome of pregna	E, g903 5/6/10 TT		2d Date of deliver						
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transicompleted by Physician/Medical E.	23c. If yes, outcome of pregnancy 23d. Date of delivery 23d. Date of delivery 1									
O. B. at the de lby the tached f		sulting in the underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?						
ords, P.O w requires that t as been signed by should be detec			-	No 3 Probably 4 ✔ Unknown						
Division of Vital Records, lat or Attending Physician: The law requires is after death. al Director: After this certificate has been signed in by the funeral director, page 2 should be striffication: To Be Completed			24a. Was an autopsy perform <u>ed?</u>	24b. Were autopsy findings available prior to completion of cause of death?						
tal Rection: The certificate ector, page Be Con	25. Was case referred to medical	26.Place of Death (Che	1 ✔ Yes 2							
Vital hysician: this certification.	examiner? 1 V yes 2 No Hospital: 1 Inpatient 2 V E		rsing Home 5 Resid	ience 6 Other:						
on of Vital Bending Physician: sath. After this certificate function, To Be Cition.	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28c. Injury at Work?	28d. Describe how in	jury occurred						
rision r Attencer death rector: 1 by the	2 Accident Investigation 28e Place of Injury - At hor	ne, farm, street, factory, office building, etc.	28f. Location (Street	and Number or Rural Route Number, City						
Division of Hospital or Attending 24 hours after death. Funeral Director: Aft stely filled in by the fune al Certification:	4 Homicide determined (Specify)		or Town, State)							
Division To the Hospital or Attention within 24 hours after death To the Funeral Director: completely filled in by the Medical Certificati	29a. Certifier 1 Certifying Physician: To the best of my knowledge one) 2 Medical Examiner: On the basis of examination and manner stated.									
F S F S	29b. Signature and title of certifier	29c. License number	I .	Date signed (Month, Day, Year)						
00	30. Name and address of person who completed cause of death (Item 2	O.C.M.E.	Ар	ril 29, 2010						
12/1		^(3a) 11 Penn Street, Baltimore, MD 212	201							
State Registrar	31. Date filed (Month, Day, Year) 32. Refisitiar's Signature MAY 0.5. 2010	1 barles								
DHMH 17 Rev 1/2001	The second of the second of	ORIGINAL	OCME							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month 2 Di D Catherine 7.35 A-M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Carrol1 Westminster 5. Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Min. 1 M 2XXF Months Days Hours (Month, Day, Year) 8/9/1917 Country) **Director** 213-01-6164 92 DE Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location the Medical Examiner must be notified at Director 1 Yes 2XNo MD Carroll Hampstead 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 4501 Millers Station Rd. 21074 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Black White etc. I Hygiene. other than "natural", or þ 1 Never Married 2 Married 1 Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: 3 XWidowed 4 ☐ Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 1Ó Sales Associate Hutzler Dept. Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental Fishers is marked or Max M. Schiffner Mae Kemp Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 sl Health a Department of Health Important: If item 27 Barbara Gillan/Daughter 4501 Millers Station Rd., Hampstead, MD 21074 3altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State any injury or conce. 1 X Buria 2 ☐ Cremation 3 ☐ Removal from State 4 Don on 5 Other (Specify) Millers UMC Cemetery 5/6/2010 Manchester, MD 21. Signature of Funeral Service Ligens ²²Name and Address of Facility</sup>Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Cardiomy vpath Immed ate Cause (Final Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 5 Other (specify) signed by the a 1 ∐ Yes ∠u 9 ∐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy performed 2 🗗 No certificate 1 Yes or Attending Physician: Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral (27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28h Time of 28d. Describe how injury occurred 5 Pending 1 Natural work 24 hours after death. Funeral Director: A 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital o within 24 hours af To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 13950 LMV Name and address of person who completed cause of death (Item 23a) (Type, Print) (tem 23a) (Type, Print) 447, East-Main Street Westminster MD 21N7 Hosain MD

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 02:30 AM May 2010 JOHN EDWARD SAFFELL 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Square Hospital Center Baltimore Rosedale If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Aug. 28 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Days Hours Ï934 1 ☑ M 2 □ F Marvland Aug. 75 215-30-8156 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 1 ☐ Yes 2 X No Maryland Baltimore Baltimore County 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21221 726 Corby Rd. 12. Was Decedent Ever in U.S. Armed Forces? ★★★★ 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 ☑ No Specify: White 3 Widowed 4 X Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bricklayer Local Union #1 3 yrs. N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Golder Saffell Ethel Ehrhardt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 726 Corby Rd. Baltimore, Md. 21221 Tina Harris (Daughter) 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5~7~2010 Holly Hill M. G. Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) ign tu of Funeral Service Lice see Lassann Funeral Home 7401 Belaír Rd. Baltímore, Md. 21236 OHO Sooth 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiogenic disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

law requires that the death certificate be executed Box 68760, P.0. the signed by Division of Vital Records, page 2 should certificate this

Physician

/Medical

Examiner

Examine attending physician and for use as the burial-trans Physician/Medical ≥ Completed Be Certification: To funeral After t the filled in by

Physician

/Medical

Examiner

Funeral

Director

show

Director

Funeral

Completed

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatih and Mental Hygiene. Important; If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Exercited in the notified at

3altimore, Maryland 21215-0036

the Hospital or Attending within 24 hours after death. **To the Funeral Director**; A

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

avial

29c. License number RES 00000

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my opinion, death accurred at the time.

29d. Date signed (Month, Day, Year)

Drive Batternote, MD 21237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 rawad Flanklin

32. Registrar's Signature 31. Date filed (Month; Day, Year)

and manner stated.

ORIGINAL.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AMP11 30 2010 Christine Schertle 15 52 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Center Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 - M 2 - XF Days Min. Hours 219 40 5502 August 8,1943 Viftifia Director Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford 1 ☐ Yes 2 🛣 No Joppa 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 401 Timber Lane 21085 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2XX No Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: White 3XX Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Housekeeping-Own Home permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Banner McCloud Tiny Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Schepers (Daughter) 5107 Meridy Avenue Baltimore, Maryland 21236 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Metro Crematory May 4 2010 4 Donation 5 Other (Specify) Baltimore, Maryland Signature of Funeral Service Dicenses . 22. Name and Address of Facility Lassann Funeral Home Inc 7401 Relair Road Baltimore Maryland 21236 23a. Part 1. Enter the disea of, or complications that cause 1 th shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Fibrosis Physician/ ulmonary disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for as a consequence on Examir Cause (Disease or linjury that initiated events resulting in death) Last ysician and e burial-trans Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the attending abovers. Box 68760 attending physi IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Coronary why disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖔 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? Yes 2 X No death? 2 🗆 No 1 Tes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) examiner?

1 \(\sum \) Yes 2 \(\sum \) No Hospital: Other: Hospice 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate; 28d. Describe how injury occurred 1 Natural 5 \square Pending iniury work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 XCertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) R149194 Manil 30, 2010 man 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (hales MD 21204 Touson, Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Jong Shik Son 2. Date of Death Month 6:10 P.M May 02, 2010 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death Baltimore County 10125 Fountaine Drive Baltimore th ly, Year) 9. Birthplace (State or Foreign Country) Choons July 17,1921 Choong Book, Korea 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1**⊠** M 2□ F 88 113-56-3008 July Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Howard County 1 ☐ Yes 2 【▼No Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6150 Forland Garth United States 21045 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Korean 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Wrist Watch Repairs N/A 03 Wrist Watch Repairman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hong Bum Son Yea Suk Min 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21163 2115 Ganton Green unit#105 Woodstock, MD. Ms. Eugenea Sohn (Daughter) 20b. Place of Disposition (Name of Dulaney, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 8,2010 Timonium, Maryland Memorial Gardens uture of Funeral Service Licen de Peaceful Alternatives Funeral & Cremetion Center Peaceful Alternatives Fundanti Lender and Timonium, airt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. 2325 York Road Timonium, Maryland 21093 Approximate Interval Between Onset and Death Immediate Cause (Final disc ase or condition re-ulting in death) Dic to (or as a consequence of): Duello (or as a consequence of) Vasan 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 ☐ Pregnant at time of death ☐ Unknown Month Day Year 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Daughter's Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Residence 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28h Time of 28d. Describe how injury occurred

be executed 68760 requires that the death certificate Box P.0. Vital Records, Physician: The of this Division Hospital or Attending death, within 24 hours after death To the Funeral Director:

Physician

/Medical

Examiner

Director

Funeral

2

Completed

Be

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Funeral

Director

d other than "natural", or items 23a or 28a-f show event, it a Madical Exp., iling must be notified at

death v

72 hours after

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If Item 27 is marked other any injury or other traumatic event, II

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine sician and burial-trans attending physician for use as the buria Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ed by the 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ page 2 should Completed funeral director. 25. Was case referred to medical Be examiner? 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) After t 27. Manner of Deat 1 Natural 5 Pending investigation 1 ☐ Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 🗌 Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated. 29b. Signature and title of certifier

LYGIN

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EING OH

MAY Q5

31. Date filed (Month, Day, Year)

State Registrar

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1, Decement's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ onth aam m Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Baltimore 118 N.Fulton Avenue If Under 1 Year | If Under 24 Hrs.
Months Davs Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1-2-1956 Year) 54 MD Director 220-66-0460 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or lother traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Baltimore MD n/a 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21217 USA 2118 N. Fulton Avenue Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces? þ 1 Never Married 2 M Married Yes Baltimore, Maryland 21215-0036 African-American 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates. Completed 3 Widowed 4 Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) 1 and 2 should be filed within f Health and Mental Hygiene. item 27 is marked other thar Domestic Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Marie Pringle David Dinkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2118 N. Fulton Avenue, Baltimore, MD 21217 Elton D. Sharpe/Husband 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Donation 5 Other (Specify) Woodlawn Cemetery 5-6-2010 Woodlawn, MD 22. Name and Address of Facility Wile Funeral Home P.A. of Balto. Co. Signature of Funeral Service Licenses 9200 Liberty Road, Randallstown, MD 21133 23a. Part . Enter the disease, or complications that cause shock, or heart failure. List only one cause on each line the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Medical P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy Physician/ 23b. Was decedent pregnant 23d. Date of delivery atten for us Ectopic pregnancy in the past 12 menths? Day Month Year 5 Other (specify) Pregnant at time of death been signed by the a should be detached Unknown Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an cate has by page 2 s prior to completion of cause of death? autopsy certificate 2 No Yes **Division of Vital** funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 1 Inpatient 2 I ER/Outpatient 3 I DOA 24 hours after death.

Funeral Director: After this leted filled in by the funeral dil 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 1 Natural Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Iv ury - At home, farm, street, factory, office but in to be cify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29c, License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Date filed (Month, Day, Year)

MAY 05

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ April 28, Soma Donald 6:00 a.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9017 Charred Oak Drive Montgomery Bethesda Social Security Number Sex 1X M 2 □ F 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. Date of Disc. (Month, Day, Year) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Director South Dakota 503-14-5402 92 Nov. Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a State 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No MD Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9017 Charred Oak Drive 20817 United States within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. WW II 1 ☐ Yes 2 🗓 No Specify: White Completed 3XXWidowed 4 Divorced the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Federal Government Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 011ie Soma Opa1 Sueter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jon C. Soma / Son 9017 Charred Oak Dr., Bethesda, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Gate of Heaven Cem. 4 ☐ Donation 5 ☐ Other (Specify) May 5,2019 Silver Spring, MD Signature of Funeral Service Licensee 22. Name and Address of Eacility
Rapp Funeral and Cremation Services Gist Ave., Silver Spring, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Atherosclerotic Cardiovascular Disease disease or condition resulting in death) years Medical Due to (or as a consequence of) Examiner Hypertension 10 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 ☐ Ectopic pregna5 ☐ Other (specify) in the past 12 months? Pregnant at time of death Unknown Day Year been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown No 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has autopsy 1 ☐ Yes 2 ☐ No Yes nours after death.

neral Director: After this certifical filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: မ 1 🗌 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) __ Homicide determined 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signatu

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30. Name and addre

31. Date filed (Month, Day, Year)

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State Registrar ause of death (Item 23a) (Type, Print)

32 Registrar's Signature

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Physician	1. Decedent's Name (First, Middle, Gladys Taylor	Last)				2. Date of De	eath 2Day	2ďÎH	3. Time of I	Death AM	
/Medical Examiner	4- F-19-N		ome	4b. City, Town, or Crisfie		h		ounty of Death			
Funeral Director	5. Social Security Number 213–24–0857		(In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days							
Maryland -f show fied at	Usual Residence of Decedent 10a. State 10b. County MD Some	rset	10c. City, Town or Lo					1	0d. Inside City	-	
th with the Mar 23a or 28a-f sl ist be notified		ay		10f. Zip Code 21817			10g. Citize	en of What Cour A	itry?		
Ind 21215-UU36 be filed within 72 hours after death with the Maryland tital Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Be Completed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? d 1 ☐ Yes 22 N If Yes, Give Year or Dates:	0	Was Decedent of His If Yes, specify Cubar 1 □ Yes 2፟፟፟፟ No	n, Mexican, Puerl	pecify Yes or No to Rican, etc.)		1. Race - Americ Black, White, Specify: whi	etc.		
Z1Z15-UU36 ed within 72 hours af ed within 72 hours af ner than "natural", or er than "dedical Exam t, the Medical Exam Completed by F	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5-	(Give	dent's Usual Occupa kind of work done d DO NOT use retired) oftsperson	uring most of wo	rking	16b. Kind	6b. Kind of Business/Industry un			
© % d ⊠ S o	17. Father's Name (First, Middle, La	ast)			18. Mother's Nar	me (First, Middle	, Maiden S	urname) unk			
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Baltimore, Mar permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum once.	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☑ Donation 5 ☐ Other (Spe	ecify)		natory or other place	t t	Date		ation - City or To			
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Physician /Medical Examiner	shoot, or leart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a										
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State Registrar DHMH 17 Rev 1/2001		2010 Leve	The .	bare							

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene

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760	or Attending Physician: The law requires that the death certificate be after death. Director: After this certificate has been signed by the attending physicii in by the funeral director, page 2 should be detached for use as the but	Physician/Medical			d											
88	certifi	M/ue	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outcome	of pregnancy	oth 3 🗆 I	Ectopic pr	ognan.c	m.,				23d. Date of	delivery	
Bo	death he atte	/sicia	in the past 12 i 1 ☐ Yes 2 ☐ 9 ☐ Unknown	No	4 Pregnant a			Other (spe		, y				Month	Day	Year
P.O. Box 68760	requires that the des been signed by the s should be detached			icant conditions co	ntributing to death t	out not resultin	g in the und	derlying ca	ause giv	en in Part	И	23e. Did	tobacco	use contribute	to the ca	use of death?
35,	uires t in signi uld be	Completed by	Alzhei	mer De	mentia,	Inter	1	ent	H	triol	<i>y</i>	1 🗆	Yes 2	2 ■ No 3 □	Probably	4 🗌 Unknown
Division of Vital Records,	aw req as bee 2 shor	plet	Fibrill	ation f	tbolomin	ral 1	tyste	rec	ton	ny		24a. Was	opsy	prior	to complet	ndings available tion of cause of
Re	: The la			, ,			/			<u> </u>		per	formed?	death No 1 □	n? Yes 2. ₩	No
/ital	sician certifi irector	To Be	25. Was case referre examiner? 1 Yes 2	_	Hospital:	ient 2 🗆 ER/	Outpotiont	2 □ DO	Low	or'	ath (Check o		.1	C - Other (C		-
of \	ig Phy ter this neral d		27. Manner of Death	n	28a. Date of inju	iry 28b	outpatient o. Time of injury		c. Injury work	y at				6 Other (Sp iry occurred	эесіту)	
ion	tendir Jeath. tor: Af the fur	Certificate:	1 Y Natural 2 Accident 3 Suicide	5 ☐ Pending Investigation 6 ☐ Could not be				М	1 🗆	Yes 2	_					
ivis	I or At after o Direct	Cert	4 Homicide	determined	28e. Place of Inj building, et		farm, stree	t, factory,	office		28	f. Location City or To		nd Number or e)	Rural Rout	te Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s	Medical		Certifying Phys Medical Examir												and manner stated
(2)	the H thin 24 the Fi	Me	only one) 3		e Practioner: To the			ath occurre	ed at the	e time, date			the cause	(s) and manner	as stated.	
	vit Sor		29b. Signature and	E ISTOS	MD					e number 5-000)			ate signed (Mo 4 / 2 3 / 2		redr)
	1.		30. Name and addre	ess of person who co	ompleted cause of	death (Item 23a	a) (Type, Pri			1 -	10	0	- I	01.		
	4		Penno 31. Date filed (Mont	h (let Vagri)	2evelet	ar's Sindatura	ID	Sino	<i>u</i> ∨	169 bi	tal .) + e	50	Gimo	~C_	
	Stat Registra		MAY	05 2010	August.	a, o dionature	Sail									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month **Debbie Ann Tiebosch** May 2, 2010 8:13 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Frederick Frederick Frederick Memorial Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year) Director 216-74-6654 Feb 18, 1958 Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Frederick Mount Airy 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 23a Funeral 402 N. Main Street items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married 9 þ Yes Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. and Mental Hygiene.
is marked other than "natural". If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Adminstrative Assistant **Healthcare Administration** of Health and Mental Hygi fitem 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Jasper Cleon Simmons Eula Virginia Adcock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Tiebosch Spouse 402 N. Main Street Mount Airy, MD 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State o Page 1 Burial 2 🗆 Cremation 3 🗆 Removal from State injury or Important: 4 ☐ Donation 5 ☐ Other (Specify) May 07, 2010 Mt. Airy, MD **Prospect Cemetery** of Funeral Servi 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Part 1. Enter the disease, or complication at shock, or heart failure. List only our suse on e 23a. Part 1 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition resulting in death) Medical to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examir as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Ectopic pregnancy ò Month Day Year Other (specify) Pregnant at time of death the hed 9 Unknown g Unknows P.O. ed by t signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Physician: The law requires Completed 3 Probably 4 Unknown 1 Yes No page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred Hospital or Attending 1√ Natural injury 5 Pending 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier MDD 35106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year

05 2010

Myung Hee Nam 400 West 7th Streer Frederick, MD 21701

32. Registrar's 3

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TTEM#10c, perFH, G903, 5/5/2010, WS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death A Month Physician/ Z Payto 7.57 M 20 D Grant Vintes Garnet Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner timore Washington Medica TUR (enter ni If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Days Hours Min. 1 1 1 1 2 1 9 30 New York 104-24-7292 79 Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a State 10c. City. Town or Location filed within 72 hours after death with the Maryland Director Severn Glen Burnie 1 Yes 2 No MD Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 21144 U.S.A. 7916 Quaterfield Rd 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry
Department (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. of Defense Intelligence Army years e 1 and 2 should be filed with of Health and Mental Hygies If item 27 is marked other in other traumatic event, the marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Vintes Ida Mae Cook William McHenry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7916 Ouaterfield Rd., Glen Burnie, MD21144 Ann Vintes(wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Important: If it any injury or o once, cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Arlington, VA 4 Donation 5 Other (Specify) Arlington Cem. unk 21. Signature of Funeral Service Licenses josephadhes of Brown Jr. Funeral Home Fulton Ave., Baltimore, MD 21217 2140 N. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter ondenying Cause (Disease or iinjury Due to (or as a consequence of): as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death page 2 should be detached Linknown g Unknown q Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has 1 Tes Yes or Attending Physician: 24 hours after death.

Funeral Director: After this certificeted filled in by the funeral director, Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital ြို Other: 2 T No 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury 5 Pending Natural M 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Hospital Medical 29a. Certifier Decrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one nd title of certifie 29d. Date signed (Month, Day, Year) 29b, Signature 54 who completed cause of death (Item 23a) (Type, Print) s of person mn 30. Name and addre OA 0 31. Date filed (Month, Day, Year) 32. Registrar' State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MAY Month Physician/ Day CHARLES E. WAGNER 2010 3:10 P. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE OAK CREST CARE CENTER PARKVILLE Age (In yrs. last birthday) Social Security Number If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 6/23/1925 Country) MARYLAND Months Hours Min. 1 X M 2 - F 219-18-7185 Director 84 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director MD 1 Yes 2 X No BALTIMORE LUTHERVILLE 10e. Street and Number 10f, Zip Code ō 10g, Citizen of What Country? of Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or
other traumatic event, the Medical Examiner must be I Funeral 4 SHADY BROOK COURT 21093 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 þ 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 X Widowed 4 Divorced Year or Dates. WWII Completed WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) MANUFACTURING WAREHOUSEMAN 8TH GRADE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JOSEPH WAGNER RUTH N. THOMPSON . Page 1 and 2 shou ment of Health and tant: If item 27 is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLES E. WAGNER, JR./SON 4 SHADY BROOK COURT LUTHERVILLE, MD 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 01= 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or 4 Donation 5 Other (Specify) 5/8/2010 BELAIR, MD MEM. PARK Signature of Funeral Service Licensee MOO217 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, LOCH RAVEN BLVD. TOWSON. S 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Due to (or as a consequence of) the burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical wagne Box 68760 as IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 2 No the 9 Unknown 9 Unknown Charles Records, P.O. cate has been signed by page 2 should be detact Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Vascular Dementia 1 Yes a No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 1 ☐ Yes 2 ☐ No Yes director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) filled in by the funeral 27. Maruer of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work' 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier сотрыете dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year)

Registrar

State

31. Date filed (Month, Day, Year)

MAY 05

tho completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

R171944

Harrison care 8800 walthy Blvd, Parkville, MD 21234

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last)
Evelyn L. Williams 2. Date of Death Physician/ Month P^{M} 2010 3:06 May Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🗓 F Months (Month, Day, Year 214-14-7510 Director Yrs July 10, 1918 Marvland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Baltimore Parkville 1 ☐ Yes 2 X No 10e Street end Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2805 Jomat Avenue U.S.A. 21234 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 X Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Secretary 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Magdaline Rosenberger Maurice Hoxter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21234 9142 Covered Bridge Road, Parkville, Maryland 19a. Informant's Name/Relationship (Type, Print) Ronald Williams/ Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Morel and Memorial Park May 1 X Burial 2 Cremation 3 Removal from State Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 21. Signature of Funeral Service Licenses 22 Name and Address of Facility | Chapel & Cremation Services 8800 Harford Road, Parkville, Maryland 21234 23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Impaediate Cause (Final Physician/ disease or condition resulting in death) ha Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death Day 1 Yes 2 Part II. <mark>Other significant condition</mark>s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 s performe 2 1 Yes 25. Was case referred to medical B B 26. Place of Death (Check only one) examiner? Hospital: Other: ၉ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide work's 5 Pending To the Hospital or Attendir within 24 hours a fer death To the Funeral Director: Af completed filled in by the fu 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie retifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and tit of certifie D0056296

State

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iams

500 Upper Chesapeake

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sig

Jasan Birnbaum, M.Q

31. Date filed (Month, Day, Year) **MAY 05 2010**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month 9=10 Jewell Weiss 2010 Medical Mav 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 36 Stillwood Circle Baltimore Baltimore Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🔀 F Hours Min. (Month, Day,) Year) Director 559-60-0700 1943 Pennsylvania June Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f Maryland 1 Yes 2 No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? must be Funeral 36 Stillwood Circle 21236 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Bace - American Indian Examiner Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. and 2 should be filed within 72 hours after of Health and Mental Hygiene. P. þ 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Specify: Completed 3 Widowed 4 Divorced Year or Dates White Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Social Security 12 <u>Claims Representative</u> Adminstration Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Louis Weiss Adele Perelman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheila Bucklinger (Sister <u>9616 Villagesmith Way</u> Burke, VA 22015 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Evans Funeral Chapel-Bel 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 200 Forest Hill, Maryland 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services-Parkville 21. Signature of Funeral Service Licenses 8800 Harford Road Parkville, Maryland 21234 23a. Part 1. Enter the diseas, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or than failure. list only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ therosclere disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Esqueritially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Exami Hunario do no Due to lor as a conselluence of): resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month 4 ☐ Pregnant at time of death g ☐ Unknown 1 Yes 2 No 9 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 XNo 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year)

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9105

32. Registrar's Signature

602U

15 epul

31. Date filed (Month

D59187

Fronklin Square Dr. State # 309 Boltimone mo 21237

03

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician rederich 2010 /Medical Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. | 12-30-1964 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 112-58-2483 45 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 X Yes 2 ☐ No Funeral Director must be notified MD n/a Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ō items 23a 21207 3604 Woodbine Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 X No Specify þ Specify: African-American 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. I other than " event, the Mer Elementary/Secondary (0-12) 9th College (1-4 or 5+) Security Guard Security 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked Frederick Wilson Jr. Patricia Delain ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Deborah A.Plumer 3604 Woodbine Avenue, Baltimore,MD 21207 27 permit. Pages 1 and Department of Health Important; If item 27 any injury or other troone. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metro Crematory 5-8-2010 Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home P.A. of Baltimore Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Par/1 Enter the disease, or complications that construction or heart failure. List only one cause on self-mediate Cause (Final used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ach line. Approximate Interval Between Onset and Death **Physician** disease or condition /Medical resulting in death) **Examiner** Seque flany list co relitor s, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) physician s the buria Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 3 Ectopic pregnancy for in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) Yes 2 No be detached Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 LINO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 1 Yes 2 No 2 ER/Outpatient 3 DOA ၉ filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 5 Pending investigation 1 🗌 Yes 2 \square No 2 Accident I or Attend after death Director: A 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) determined 4 Homicide 24 hours Hospital 29a. Certifier (check only 1 Fortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29c. License number 29b. Signature and title of certile 29d. Date signed (Month, Day, Year) RES-000 5-2-2010 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

600 North Wolfe St, Baltimore, MD, 21287

Hernandez

32. Registrar's Signature

Estebes

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FURITMUIDIN Month Day Year :00A Mallom Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death a lf Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign (Month, Day, **№** M 2 □ F Months Hours Min **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland the Medical Examiner must be notified at 10d. Inside City Limits Director 1 XYes 2 ☐ No ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Armed Forces Black, White, etc ō δ 1 Never Married 2 Married 2 No Maryland 21215-0036 ☐ Yes If Yes, Give Year or Dates. 1 ☐ Yes 2 📈 No Specify: "natural", 3 Widowed 4 Divorced Specify: Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Sister 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 1 X Burial 2 Cremation 3 Removal from State 22. Name and Address 4 ☐ Donation 5 ☐ Other (Specify) Signal re f Funeral Service License 23a. Part . Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final END-Stage Restrictive lun Disease Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year 2 \square No completed filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 ☑ No 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 ∐No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 1 Other (Specify) ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pendina 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) To the Hospital of within 24 hours a To the Funeral D Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, ueau occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier 29c. License number MS ENAPahrem D D0057465 4/29/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, NO. 2/209. KajaparKER MD 2835 SMITH AV- 5203,

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month 8:30 May ler 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner lanor **Funeral** Months Hours 1X M 2□ F Carolina Director North Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Product Examinant must be notified at 1 Yes 2 □ No Directo more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 MYes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2XNo Specify þ 3 Widowed 4 □ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Q t of Health and Mental Hy, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type. Print) (daug iter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 07(08 Pages 1 and 2 New wark 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State permit. Pages 1 Department of I Important: If ite 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5 ☐ Other (Specify) 21. Signat of uneral Service Licensee JOSEPH 12222 W. No Home, P. A. Baltimore, Md 21216 23a. Part 1 Enter he disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) Advance /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.O. s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy perform 2 NINO 1 ☐ Yes 1 □ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Medical Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Natural Accident 5 ☐ Pending investigation 1 □Yes the within 24 hours after deat To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie and manner stated 29b. Signature and title of certifier who completed cause of death (Item 23) (Type, Print) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 135PM /Medical Facility Name (N-hot institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltmore SONS HOSPILE dallstow MA 8. Date of Birth (Month, Day, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2□ F 8 Months Days Hours Min 265-22-775 **Director** DE Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 23a or 28a-f show 10d. Inside City Limits Examiner must be notified at 1 Xyes 2 □ No Directo more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 Funeral items 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces?
1 XYes 2 □ No 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 X No δ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than " permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any Injury or other traumatic event, ITEM any Dioce. Elementary/Secondary (0-12) College (1-4or 5+) Provid 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည 19a. Info nt's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of wite I Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 4 Donation of Funeral Service Licer 23a. Part 1. Inter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician cotristans /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Dille to (or es a nonsequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE f yes, outcome of pregnancy □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen a 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform 2 🗆 No 1 ∐ Yes Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? metagi Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Other (Specify) 2ñNo ပ္ 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 41956Y 27. Mapper of Death 28a. Date of Injury (Month, Day, Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation within 24 hours after death. To the Funeral Director: A 1 □ Yes 2 □ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Zertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 9 29d. Date signed (Month, Day, Year) 2010 Name and address of person who completed cause of d atb (Item 23a) (Type, Print) 6190 Genzeto

Registrar

State

31. Date filed (Month, Day,

Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** DV /Medical 4b. City, Town, or Location of Death 4c. County of Death acility Name (If not institution, give street and number, Examiner Vortnue 05/ Town 1 Birthplace (State or Foreigr Country) Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Min. Months Days Hours 1 □ M 2√2 F 100 Director 212-09-0811 02 10 VA വ Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exturbing to asset the traumatic event, the Medical Exturbing to the content of the Director 1XYes 2 No Baltimore NA MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 U.S.A. Funeral 4103 Fairfax Road Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 □No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 þ If Yes, Give '7' Year or Dates: 1 ☐Yes 2 No Specify Black Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Licensed Practical Nurse Private Duty 2yrs 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dabney Marshall Missoura Marshall ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4103 Fairfax Road, Baltimore, Md 21216 Marita Harvey-Sister-In-Law 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/6/2010 Baltimore, Mt. Zion 21/Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 23a. Part 1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, r heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death **Physician** /Medical (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physiclan: The law requires that the death certificate be executed that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of) P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnapt 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 9 Unknown 9 Unknow cate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 Probably 4 Unknown 1 TYes Completed . Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 [J] M 2 🗷 No 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 DV6 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 3 ER/Outpatient 3 □ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 atural 5 Pending investigation filled in by the fi 1 □Yes 2 □ No Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my opinion death accurate. within 24 hours a 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature title of contifier 29c. License number 2062650 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) anveer (zai Di Old CONT 5401

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** AM OLIVINE M. YEE MAY 2010 /Medical 4c. County of Death 4h. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Good Samaritan Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6/3/1918 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Months Days **Funeral** Hours Min. **⊅** M 2 □ F CHINA 91 Director 216-13-1249 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 28a-f show 1 ☐ Yes 2 ☐ No Director BALTIMORE PARKVILLE MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number ö 1109 PELHAMWOOD ROAD 21234 TRINIDAD or items 23a Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ MNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Baltimore, Maryland 21215-0036 Specify. Specify: à ASIAN 3X Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 6TH_GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNAVAILABLE UNAVAILABLE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health an
Important: If item 27 is
any Injury or other trau TOMMY YEE/SON 1109 PELHAMWOOD ROAD BALTIMORE, MD 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place)
DULANEY VALLEY MEM. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/11/2010 COCKEYSVILLE, MD 4 Donation 5 Dother (Specify) GARDENS 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee MOO217 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) GEPSIS Physician /Medical Due to (or as a consequence of): INFECTION Examiner TRACT URINARY Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dise to for as a nonsequence off Examiner burial-transit Due to (or as a consequence of) Box 68760, attending physician pe Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9 I Inknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 DEHMORATION 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed HUPEROSMOLAR STATE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy HYPERNATREMIA perform certificate 25. Was case referred to medical examiner? funeral director, 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death.
To the Funeral Director: A completely filled in by the fu death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar ROSEMALLE +

MAY 0 5 2010

DHMH 17 Rev 1/2001

5601 Loch Raven Boulevard, Baltimore Maryland 21239

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) APRIL 30, 2010 2:20 MILTON YOFFEE 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) N/A BALTIMORE KESWICK MULTI-CARE CENTER 9. Birthplace (State or Foreign Country)

LATVIA If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number 7/23/1919 Months Days Hours Min. Yrs. 90 203-10-2929 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 TYes 2 No BALTIMORE BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 21208 USA 1 ELM HOLLOW COURT 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married WHITE 1 ☐ Yes 2 🛣 No Specify Specify. 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **SALES** RETAIL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) WISHKIN YOFFEE SARAH MAX 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 ELM HOLLOW COURT, BALTIMORE, MD GAIL WOHLMUTH/DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of central place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) CHIZUK AMUNO CEMETERY: 5/4/2010 21. Signature of Funeral Service Licers 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one of the one can be one each line. Approximate Interval Between Onset and Death atherescluster Cardenasenlar Immediate Cause (Final disease or condition resulting in death) End-Stage ears Misease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. aritery disease 2☑No 3☐ Probably 4☐Unknown 1 ☐ Yes Prestorte career 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe 2 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Physician/Medical ģ Completed

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permit. Pages 1 and 2 s
Department of Health ar
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Physician /Medical

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25. Was case referred to medical examiner?

1 Yes

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier IT habille The thegre rd 29c. License number D13657

29d. Date signed (Month, Day, Year) april 30,2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOERRELIR, 700 W. 40 th STREET, BOLTIMIRE, MD 21211 TI DE MIEUE

31. Date filed (Month, Day, Year)

32. Registrar's Signature

MAY 05 2010 Sever S. park

Registrar

State

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1			5. Social Security Number 6. S) Say [7 Ag	e (In yrs. la	et hirth	TIMON fav) If Under 1 Year	I If Under 24 Hrs.	8. Date of Bir	th	Balty	thplace (State or Foreign				
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	and show	ē	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town	or Location	<u>-</u> _				10d. Inside City Limits				
	Maryli 28a-f notified	Director	Maryland Balti	more			Halethorpe					1 ☐ Yes 2 🏝 No				
	e filed within 72 hours after death with the Maryland Hygiene. Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at.		10e. Street and Number Brewster 1217 Brester Str	eet			10f. Zip Code 21	227			tizen of What Co ted Sta					
	death items	Funeral	11. Marital Status	12. Was Decedent 8 Armed Forces?			13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No- o Rican, etc.)		14. Race - Ame Black, White					
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nore	age 1 a sunt of H trick		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐		C	emetery	Disposition (Name of crematory or other place	Hay	1, 2010	!	ocation - City or	Maryland				
Baltimore, Maryland 21215-0036	permit. Page 1 Department of Important: If i any injury or once,		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice					ss of Facilit Cre		Socie	ety of N	Maryland, Inc				
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876	tificate ing phy as the	Medi	IF FEMALE:		_											
Box 68760	attend attend I for use	ician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Feta	Fetal death 3 Ectopic pregnancy					23d. Date of de Month	livery Day Year				
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	with Control		29b. Signature and title of certifier	100	2		29c. Licens	0			te signed (Mont					
	140		30. Name and address of person who	completed cause of c	leath (Item	23a) (T	7 7	7624			5/1/20) ()				
	10.		Jennifer Hauf, 31. Date filed (Month, Day, Year)	CRNP (2300) <u>Du</u>	lane	ey Valley R	oad,Timo	nium, Ma	aryla	and 2109	93				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Vivian Anderson 2010 | 4065 State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3 Time of Death Physician/ Month Day April 12, 2010 Medical Examiner 2030 hrs Vivian Anderson 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death 10714 Potomac Tennis Lane Potomac Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Pennsylvania Director 170-16-4404 88 1 M 2 F Feb.19, 1922 Yrs Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 XNo or 28a-f show , or items 23a or 28a-f sho r must be notified at once. Cabin John rmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland spartment of Health and Montal Hygierh. uportant: If team 27 is marked other winatural?, or items 23a or 28a-f she jury or other tranmaite event, the Medical Examiner must be notified at once jury or other tranmaite event, the Medical Examiner must be notified at once Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20818 6408 Little Leigh Ct. United States Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc 1 Never Married Married Yes 2 X No White 3 X Widowed f Yes, Give Year 4 Divorced 1 Yes 2 No specify: Specify: ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Complet Baltimore, MD 21215-0036 Own Home Homemaker 12 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Ruth Steele Frank Henry Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6408 Little Leigh Ct. Cabin John, MD 20818 Phyllis Anderson, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify. Pending Brentwood, Maryland Lincoln Crem 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute Funeral and 208 2 M01463 1040 Rockville Pike, Rockville, MD Cremation Ctr. 23a. Part I/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Approximate Interval Between Onset and /Medical Death a. Hemopericardium Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of): b. Aortic Dissection Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause c. Hypertensive Atherosclerotic Cardiovascular Disease (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and - transit The law requires that the death certificate be executed Physician/Medical attending physician or use as the burial -UNPENDED AMENDED Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy Month Dav Year past 12 months? Pregnant at time of death 5 1 Yes 2 V No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been ector, page 2 should 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed? Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26 Place of Death (Check only one) funeral director, Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene this 1 Yes After 1 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or con-1 V Natural Pending 1 Yes 2 No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 13, 2010 autall, mi 30. Name and address of purson who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) APR 2 1 2010 Registrar's Signature Registrar much

DHMH 17 Rev 1/2001

			1 _ State	partment of Health and Mental Hygiene ertificate of Death								
			Registrar 1. Decedent's Name (First, Middle, Last)	PRES. No. 2 3. Time of Peath								
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	Examir		4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital	4b. City, Town, or Location of Death 4c. County of Death N/A								
	Funeral Director		5. Social Security Number 253−57−2866 6. Sex 1 ★ M 2 □ F 7. Age (In yrs. last birthda yrs. last birthda yrs. last birthda yrs.									
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Division of Vital Records,	The law reate has bee page 2 sho	Completed	·	24a. Was an autopsy findings available autopsy performed? 1 □ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No								
Zita ✓	sician: Tr certificate lirector, pa	Be	25. Was case referred to medical examiner? 1 □ Yes 2 □ No Hospital: 1 □ Inpatient 2 □ ER/Outpatie	26. Place of Death (Check only one) ent 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)								
n of	ter this	on: To	27. Many of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year)	of 28c. Injury at 28d. Describe how injury occurred								
Divisio	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2	ertification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Accident	M 1 ☐ Yes 2 ☐ No treet, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	edical C	29a. Certifier (check only one) 1 ✓ Certifying Physician: To the best of my knowledge, deal check only one) 1 ✓ Certifying Physician: To the basis of examination and/or and manner stated.	ath occurred at the time, date and place, and due to the cause(s) and manner as stated. investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)								
	To the vithin To the comp	Me	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)								
			30. Name and address of person who completed cause of death (Item 23a) (Type	Res-000 April 25 = 2010								
			Bret Kilker	600 North Wolfe St, Baltimore, MD, 21287								
	Sta Registra	.~	31. Date filed (Month, Day, Year) NAY 0 5 2010 32. legistrar's Signature	and								

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Vear **Physician** Adele Amantea 14:03 PM 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ag 145 Hospital Baltimorelity | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | May 4, 1919 5. Social Security Number (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X**□ F New York, NY 113-03-1301 90 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show 1

Yes 2

No traumatic event, the Medical Exercises must be notified Director Maryland Prince George's College Park 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 0 4706 Cherokee Street, T-1 20740 United States 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items, 14. Race - American Indian, 11. Marital Status filed within 72 hours after 1 Tes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 2 3 XWidowed 4 ☐ Divorced 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien. Important: If Item 27 is marked other tha any injury or other traumatic events. Secretary Dept of NAVY 17. Father's Name (First, Middle, Last)
Joseph Petrini 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Tedesco ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10506 Old Ellicott Circle Ellicott City, MD 21042 Lorraine Storck -daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 5/1/2010 SilverSpring, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Bonardadv. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 Donald 0,19 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 25 days disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner weeks neumania Sequentially list conditions, if any, leading to immediate cause Enter University Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed burial-tra Due to (or as a consequence of) physician the burial Division of Vital Records, P.O. Box 68760. Physician/Medical requires that the death certificate attending p for use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Amantea, Adele 3 Ectopic pregnancy in the past 12 months? Month Day Vear 5 Other (specify) ed by the a 9 Unknown 9 Unknown s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by heart tailure 2 No 3 Probably 4 Unknown 1 Tyes Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2: diverticulitis 2 X No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Atter this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death
1 Alatural
2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a, Certifier 1 📐 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Iminglocillang, MD 26 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

MingHs; 31. Date filed (Month, Day, Year)

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0 5 2010 Leneva

Registr r's Signature

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Caton Ave, Baltimore

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Nonth Physician/ Year William E. Brode, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death Examiner 8. Date of Birth (Month, Day, Year March 22, Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**√**2 M 2 □ F Min Country)
Maryland Director 213-24-6648 1928 Usual Residence of Decede permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Yes 2 □ No Maryland Allegany Midlothian 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19700 Shaft Road 21543-U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🌠 No Specify Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 0 bakerv machine operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Howard Brode Evelyn Mae Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21543-Mary B. Brode P.O. 602 Midlothian Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗹 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Laurel Hill Cemetery April 24, 2010 Moscow Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licer Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician, resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-transit Due to (or as a consequence of) ed by the attending physician detached for use as the buria Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Year Day g 🗌 Unknown cate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No this certificate 1 🗌 Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of s after death. I Director: After th Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State 24 hours Medical TC Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 only one) 29b. Signature and title of certifier

State Registrar wowield

WONSOCK

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

00055321

Eishop Walsh Rel Cumberkund MD21502

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 17, 2010 7:30 a Brumfield Dorothy McFadden Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Country Garden Assisted Living Highland Howard Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗗 F Hours Min. Aug. Tay, Year 1914 Georgia Director 300-14-7397 95 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Tyes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funerai 20906 14400 Homecrest Road, Apt. 46 IISA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Specify: White 1 Tes 2 X No Specify: If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Teacher **E**ducation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental F is marked of Rawlinson E. McFadden Mary H. Hodges 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Jesse William Brumfield/Son 13723 Castle Cliff Way, Silver Spring, MD 20904 20a. Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State Date Aremeter, cremator or other place.
Cemetery 🗖 Burial 2 🗌 Cremation 3 🗌 Removal from State May 19 2010 4 Donation 5 Other (Specify) Arlington, Virginia 21. Signature of Funeral Service Licensee 27 Yanci Sdrgs of Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Coronary Artery Disease years Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause to impury Examine Due to (or as a consequence of) death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) anding physician ause as the burial-Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) ed by the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🗷 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Assisted Living Other: 4 Nursing Home 5 Residence 6 St Other (Specify) 1 Yes 2 No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA in 24 hours after death, the Funeral Director: After thi opleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending work? 1 ☐ Yes X Natural 5 Pending 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Fractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) April 19, 2010 D38457 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Nakul Goyal, MD 3801 International Drive, #211, Silver Spring, MD 20906 31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 21 Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Vital

of

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Physician/ APRIL 20 2010ª 14:15 M Courtland Leroy Baker Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ALLEGANY WMHS - REGIONAL MEDICAL CENTER CUMBERLAND Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8 Date of Birth 9 Birthplace (State or Foreign **Funeral** Days Hours Min. (Month, Day, Year) 1 😾 M 2 🗆 F 84 Director 220-16-6155 08/16/1925 Ohio Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 116 Karns Avenue 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes : Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Completed 3 x Widowed 4 ☐ Divorced White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Custodian Electric Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Lester Baker Rose Funk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 116 Karns Avenue, Cumberland, Maryland Adele G. Baker/ Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Memorial Park 04/24/2010 Cumberland, MD 22. Name and Address of Facility Adams Family Funeral Home, P.A. f Funeral Senice 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. SEPS 15 Onset and Death Immediate Cause (Final Physician. disease or condition Medical resulting in death) ASPIRATION PNEUMONIA Examiner quantelly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): resulting in death) Last the attending physician hed for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Vear Pregnant at time of death g 🗌 Unknown 9 Unknown יייס יפוון מוויס פרוווומנו been signed by ז funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FUNGIMEA 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perforn 1 Yes 2 No Be (25. Was case referred to medical 26. Place of Death (Check only one) 2 No Hospita မြ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b, Time of 28c. Injury at 28d. Describe how injury occurred Director: After (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pendina 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical

Division of Vital Records, P.O. Box 68760 within 24 hours a To the Funeral D

2 NRS State 29a. Certifier

only one 29h. Signat

BARRERA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.,

ROBUSTIANO

Registrar DHMH 17 Rev 7/2009 200 GLENN ST.

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

SUITE 302, CUMBERLAND,

29c. License number D14865

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anoine. Baltimore, Maryland 21215-0036 Physician/ Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760

Director

Funeral

Completed by

Be

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Examine

Physician/

Medical

Examiner

Funeral Director

State Registrar		State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7								0.1	0 1	1-07	
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a. Facility Name (if I	not institution, g	ive street and num	ber)		4b. City	, Town, or	Location of	of Death		4c. Cou	nty of Dea	th	H
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Social Security Nu		. Sex 1 □ M 2 💢 F	7. Age (<i>ln</i>) 89	rs. last birthday) Yrs.	Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	Co	untry)	te or Foreigr
216-18-1' sual Residence of I									04/26/	1920	Ma	rylan	
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. Father's Name (F	First, Middle, La	st)			2101110	are		er's Name	(First, Middle, N				
Howard			Cov	gill			Ada				Fish	ell	
9a. Informant's Na	me/Relationship	(Type, Print)		19b. Maili	ng Addres	s (Street a	nd Numbe	er or Rural	Route Number,	City or Town	n, State, Zi	o Code)	
		/ Friend	1	121	07 Ke	emp D	rive,	Fro	stburg,	MD 2	21532		
a. Method of Dispo 1 Denation	Cremation 3	Removal from	State	b. Place of Dispo cemetery, cre Cumberla	matory or o	other plac				20c. Location		Town, State	9
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Sequentially list con any, leading to im- ause. Enter Underl	mediate Iving	D		consequence of):							Few ye		
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art II. Other signifi		_		_	underlying	cause giv	en in Part I	l.	23e. Did tob	acco use co	ontribute to	the cause	of death?
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5. Was case referre examiner?	ed to medical No	Hospital:					r: Deat						
1 ☐ Yes 2/12 7. Manner of Death		28a. Date		28b. Time o		28c. Injury	4 ⊔ Nu		ne 5 Reside			ify)	
1 X Natural	5 Pending	(Mont	28a. Date of Injury (Month, Day, Year) 28b. I'me of 28c. Injury at work? 28d. Describe how injury occurred										
Annidant									28f. Location (Street and Number or Rural Route Number,				
2 Accident 3 Suicide 4 Homicide	Investiga 6 Could no determin	ot be 28e. Place	of Injury - A	ut home, farm, str					8f. Location (St.		nber or Ru	ral Route No	ımber,

attending physician and for use as the burial-tran Physician/Medical within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atte completed filled in by the funeral director, page 2 should be detached for Certificate: To Be Completed by Medical

1 Natural
2 Accident
3 Suicide
4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year))46346 MC, 4/23/10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

21502 Cumberland, MD 625 Kent Avenue, Huma Shakil, M.D.,

32. Registrar's Signature 31. Date filed (Month, Day, Year)

nds

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	State	of Maryla		artment e rtificate			Mental Hy	giene Reg. No.	010	14073	
			1. Decedent's Name (First, Midd	le, Last)								Year	3. Time of Death	
		al								April_				
1	Examin	er								th		•		
				Nursing	Center	1 11:41 1 1		A		Data of B			<u> </u>	_
н	Funeral			6. Sex 14∑M 2 □ F	7. Age (in yrs					Month, D	Year)	9. 000 9. 000 9. 000	th Korea	1
	Director				0	7				1100.		20 50u	th Rolea	_
	/land			,	10c. C	ity, Town or Lo	ocation						10d. Inside City Limits	
	Man,	ō	Maryland Anne	Arunde1	Se	vern							1 □ Yes 2 💢 No	
	h the	irec	10e. Street and Number				10f. Zip C	ode			10g. Citiz	en of What Co	untry?	
	th wit	a	8200 Clearwater	Court			2114	.4			Unite	ed Stat	es	
	ema ema	ner	11. Marital Status	12. Was D	ecedent Ever in 1 1 Forces?	U.S. 13.	Was Deceder	nt of Hispar Cuban, M	nic Origin? (! lexican, Pue	Specify Yes or N nto Rican, etc.)	0- 1			
98	or it	F.		ried 1 □ Ye	s 2X No Give							Specify:	•	
Ö	hour:	D D			or Dates:	16a Dace	dent's Heusli	Occupation			16h Kin			
21215-0036	within 72 hours efter deeth with the Maryland ene. than "naturel", or itema 23e or 28e-f ehow the Mardical Examiner mout be motified at	lete	(Specify only highe	st grade complete		(Give	kind of work DO NOT use	done durin retired)	g most of wo	orking	100.14	u 01 200.1100u		
12	iene.	Eo	Elementary/Secondary (0-12)	Part Part		n								
ğ	a filec I Hyg other		17. Father's Name (First, Middle	Last)				18.	Month					
Maryland	12 should be filed within h and Mental Hygiene. 7 le marked other than "iraumatic event, the Mau	TO E	Young Sun Chong	3				Ha	ae Woo	Lee Cho	Birth Ac. County of Death Mont gome ry Birth Day, Year) 1920 9. Birthplace (State or Foreign Country) Birth Day, Year) 1920 9. Birthplace (State or Foreign Country) 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? United States No- 14. Race - American Indian, Black, White, etc. Specify: Asian 16b. Kind of Business/Industry Electrician Idde, Maiden Sumame) Inong Imber, City or Town, State, Zip Code) rn, MD 21144 20c. Location - City or Town, State Fairfax, Virginia 1 Home rfax, VA 22032 ry arrest, Approximate Interval Batween Onset and Death Nas an United States 23d. Date of delivery Month Day Year 1 Yes 2 No 24b. Were autopsy findings available pries to completion of cause of death? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 24b. Were autopsy findings available pries to completion of cause of death? 1 Yes 2 No 1 Yes 2 No 24b. Were autopsy findings available pries to completion of cause of death? 1 Yes 2 No 1 Yes 2 No 24b. Were autopsy findings available pries to completion of cause of death? 1 Yes 2 No 25d. No 27d. Date of delivery Month Day Year APRIL 20, 2010			
lan	2 sho and f		19a. Informant's Name/Relation	ship (Type, Print)		2. Date of Death April 19, 2010 Vest 3. Time of Death April 19, 2010 Vest 5:10 P. M.								
	1 and 2 Heelth tem 27 l	Descention Name Print, According 2. Date of Death 3. Timed 3. Timed			Taura Chata									
ore	jes 1 ar of Hee If item or othe			3 ₹ Removal fr	I	cemetery, crei	matory or other	er place)	Apr	il 22,				
altimore,	tant:				Fu					0	Fair	fax, Vi	rginia	_
Bal	permit. Pages in Department of Himportant: If ite any injury or of once.		21. Signature of Funeral Service	m'7h	∼ M01	508 E	Pairfax 1902 Br	Memo addo	orial ck Roa	Funeral d, Fair	Home	VA 2203	12	
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complications th t only one cause of	at caused the dea	ath. Do not en	ter the mode	of dying, su	uch as cardia	c or respiratory	arrest,		Interval Between	
	Priysician	0 1	disease or condition	MY	LELODYSP	LASIA							Criset and Death	
1	/Medical Examiner		resulting in death)	Due	to (or as a conse	equence of):								
	Examiner	<u>.</u>	Sequentially list conditions,		to for se a conse	duence of/:								
	ted nslt	ie l	cause. Enter Underlying Cause (Disease or Injury	< "	10 (01 43 2 501100	.4401100 01).								
	el-tra	xar	that initiated events		to (or as a conse	equence of):	 -							
8760,	slcier slcier			d.										
9	tificat ig phy as th	edi					-					:: :::::		
Вох	death certifica ettending ph d for use as th	N/UE	23b. Was decedent pregnant				Tectopic pred	nancy			2		•	
	the ett	sicis	1 ☐ Yes 2 ☐ No	4□Pr	egnant at time of							MOHUI	Day 18a	
P.0	d by t	Phy		ione contribution	o dooth but not re	aculting in the u	andorhina on	eo aivon in	Dart I	23e Did	tobacco us	se contribute to	the cause of death?	
	signed I	d by	Fait ii. Other signmount condit	ions contributing t	o double but not re	ssalling in the c	indenying out	so given iii	, and it				v	١
Ö	v requ	etec		-						24a Wa	s an	24b Were a	utoosy findings available	9
of Vital Records,	2 8	dmo								auto	ากรง	death?		
ta			25. Was case referred to medic	al				26	Place of De			1 1 1 1 1 1 1	20 140	_
>	Physician: r this certificantal director,	9	examiner?	Hospital:	□Inpatient 21	☐ ER/Outpatie	nt 3□ DOA					□Other (Spe	cify)	
				28a. D.	ate of Injury Month, Day Year)		of 280							
Ö	Attending r death. • ctor: Afte by the fune	atic	2 Accident inves	igation					2 🗆 No					
Division	ospital or Attend hours after deatl uneral Director: ly filled in by the	Sertific	datas	mined 286. P	lace of Injury - At uilding, etc. (Spec	home, farm, st cify)	reet, factory,	office		28f. Location City or To	(Street and own, State)	d Number or R	ural Route Number,	
	To the Hospital within 24 hours and to the Funeral completely filled		(Check only 2 Medica	Exeminer: On the	e basis of examin	nowledge, deat nation and/or in	h occurred at evestigation, i	the time, on my opinion	date and place on, death occ	ce, and due to the curred at the time	e cause(s) e, date and	and manner a place, and due	s stated. e to the cause(s)	
	within 24 To the Fi	M	29b. Signature and title of certific	er n	0 /	7	29c.	License nu	mber		29d. Date	signed (Mon	th. Day, Year)	
	5		4 lane	The	Keal	211	D5:	2261			APRI	L 20,	2010	
-								TED C	DDTMC	MD 200	06			
							E, SIL	VEK S	rking,	, FID 209	00			
	Sta Registr		APR 21	2010	6		wed.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Wilbur Cessna, Lamont Jr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Western MD Regional Medical Center Allegany Cumberland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 ₹ M 2 □ F Months Days Hours Min onth, Day, Year) Director 83 213-24-5623 Pennsylvania Usual Residence of Decedent shov 10a. State 10b. County with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits PA Bedford Manns Choice 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 293 Watson Road 15550 Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14, Race - American Indian, Armed Forces?

1 Z Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married 1944 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. 3 Widowed 4 Divorced Specify. Completed 1945 White permit, Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Plant Manager Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ O'Neal Wilbur Cessna, Sr. Ethel Lamont June 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emma Jean Cessna / Wife 293 Watson Road, Manns Choice, PA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Rocky Gab 04/19/2010 <u>Flintstone</u> re of Funeral Service 22. Name and Address of Facility Adams Family Funeral Home, P.A. OY 404 Decatur Street, Cumberland, 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deat Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or/a a consequence of) Examin attending physician and I for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) ned by the atter e detached for u in the past 12 months? Day 4 Pregnant at time of death 9 Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 Yes 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) Other: ျှ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work?
1 Yes 2 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check

completed 5

State

Registrar

31. Date filed (Mon

29b. Signature and title of certifier

Bever/Ly

r's Signature Registr Chewa

and address of person who completed cause of death (Item 23a) (Type, Print)

Calkins, M.D.,

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

600 Memorial Avenue, Cumberland, MD

29d. Date signed (Month. Day, Year)

21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

rica Dale		1- For State	tate of Maryl	-	artment o ertificate o		and	Mental I	Hygiene	Reg. No	201	0 1407
Physicia ledical Examin	n/	1. Decedent's Name (First, Midd	lle,Last)						2. Date of D	eath Day	Year	3. Time of Death 2207 hrs
leuicai Examin	ei	Erica Dale 4a. Facility Name (if not institution	on, give street and n	umber)		4b. City, Towr	n, or Lo	cation of Dea	April 28,		c. County of Dea	
		Union Hospital				Elkton			. lo pie di		Cecil	24.
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs.			Year Days	If Under 24H Hours M	in.		Fore	Birthplace (State or eign Country) PA
	ŀ	172-68-9997 Usual Residence of Decedent	1 M 2 X F		27 Yrs	S			Ju1y	13,	1982]	PA
w any		10a. State 10b. County		10c. City	, Town or Loca	tion						10d. Inside City Limits
Aaryland 28a-f show	ខ្ន	MD Ceci	11	Che	sapeake	City				10- 0	tizen of What Co	1 Yes 2 No
th the Maryland 23a or 28a-f sho notified at once	Director		namanh DJ			2191				-		outru y ?
with the ns 23a		2936 Old Tele	12. Was De	cedent Ever in U		as Decedent of	f Hispa		Specify Yes or I	USA 10-	14. Race - Am	erican Indian, 8lack,
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Montal Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she context the Medical Examiner must be notified at once	Funeral		larried Armed F	2 X No		es, specify Cu			to Rican, etc.)		White, etc.	ite
irs afte ural", miner	2	3 Widowed 4 Div 15. Decedent's Education (Spe	vorced If Yes, Give Ye or Dates: ecify only highest gra		16a Deceder	Yes 21		specify: (Give kind o	work done	16b.	Specify: W I. Kind of Busines	· · · · · · · · · · · · · · · · · · ·
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2121 buld be fill Mental I marked ic event,		19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailin	g Address (S				umber, C	City or Town, Sta	ite, Zip Code)
y, MD 2121 and 2 should be fi ealth and Mental ten 27 is marked traumatic event,		Barbara Brooks	s / mother	•	2936	Old Te	1eg	raph R	d. Ches	ареа	ke City	, MD 21915
ore, MC es 1 and 2 sl of Health ar If item 27		20a. Method of Disposition 1 Burial 2 X Cremation	n 3 Removal f		Place of Dispos crematory or ot		f ceme	tery, 5/	1/2010	20c.	Location - City	or Town, State
Baltimore, permit. Pages 1 ar Department of Her Important: If ite		4 Donation 5 Other S	pecify:		T. Foar	d Fune	ra1	Home,	P.A.	Ri	sing Su	ın, MD
Balti permit. Departm Imports		21. Signature 1 Funeral Service	M17	de	$\frac{7}{3}$	T. Foa 8 Geor	ress of rd	Funera St. Ch	l Home,	P.A	ty, MD	21915
Physician	1	23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease	complications that of	aused the death	n. Do not enter t	he mode of dy	ring, su	ch as cardiac	or respiratory a	rrest, sh	ock, or heart	Approximate Interval Between Onset and
Examiner	1	Immediate Cause (Final disease or condition resulting in death)				l proba	ble	sepsi	.5			Death
	1	Sequentially list conditions,	b.	a consequence o	of):							
	<u>le</u>	if any, leading to immediate cause. Enter Underlying Cause		eoneupsanco s	br).							
d d	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	a consequence	of):							
vecul	dical	X UNPENDED	d	23a,PII	,27,28a	-f,per	ME	g904	6/8/10	TT		+
	oo ⊩	IF FEMALE:	AMENDED 23:	a,27, Poutcome of pres	II, per	ME g90	3 5	/6/10	TT	23	d. Date of delive	ery
ox 68760 eath certificate b attending physi for use as the bu	ian/	23b. Was decedent pregnant in the past 12 months?	ne 1 Live I		2 Fe	etal death	3	Ectopic pregr	nancy		Month	Day Year
Box e death o the atten ed for us	Physician/M	1 Yes 2 No 9 Uni	known 9 Unkn		eath 5 Ot	her (Specify)	_				Feb 11, 20	10
Records, P.O. Box 6876(The law requires that the death certificate cate has been signed by the attending phyrage 2 should be detached for use as the bear as the	S S	Part II. Other significant condit	_			underlying cau	se give	en in Part I.		_		to the cause of death?
ls, P.C quires that en signed laid be deta		<u>Nephrolithia</u>	sis and u	osepsis	3				1 Y			obably 4 Unknown
of Vital Records, ng Physician: The law requir ufler this certificate has been s meral director, page 2 should the	Completed								auto	opsy ormed?		completion of cause of
, in		25. Was case referred to medica				26 PI	lace of	Death (Check	1 Yes	2N	lo 1 🗸	Yes 2 No
Vital hysician this cert	۱ă	examiner? 1 ✓ Yes 2 No	(Hospital:	Inpatient 2	ER/Outpatient		12.	205: [ing Home 5	Reside	ence 6 Oth	er:
ding Ph After th funeral	의	27, Manner of Death	28a. Date (Month	of Injury n, Day, Year)	28b. Time of I	· · _		it Work?	28d. Describe	how inj	ury occurred	
ivision or Attendi after death. Director:		2 Accident Pend	stigation Fu	/28/10	Fd 9:15) Рш		2 X No	unk	1011		
Division tall or Attendi	Certification;	3 Suicide 6 X Coul 4 Homicide deter	Id not be rmined (Specify)	e of Injury - At h	l at res			aing, etc.	or Town,	State)2 eake	936 Tel	Rural Route Number, City egraph Road MD
		20a Cortifier	hysician: To the be	st of my knowled	lge, death occur	red at the time	e, date	and place, an				
To the within To the comple	ᅙ	one) 2 Medical Exa	mîner: On the basis and manner s		and/or investigat				at the time, dat			
	Σ	29b Signature and title of certific	146	1/0/1/	20,00	29c. Lic	ense n C.M.			1	Date signed (No. 1)	fonth, Day, Year)
	ŀ	30. Name and address of person	who completed cause	se of death (Item	n 23a)					1.,,,,,,		
		Victor Weedn MD JD	Assistant Me			enn Street	t, Bal	timore, ME	21201			
Sta Registr		31. Date filed (Month, Day, Year)		egistrar's Signat	arke							

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		Pleas	se Type or Prin			delible Ink. artment of F			-		_		
		1 - For State Registrar	Oldio o. m.	ar y rar ra		rtificate of				eg. No.	0010		076
Physic /Medi		1. Decedent's Name (First, Middle, Janet F Dom	Last)						Date of Dea Month pril	th Day 20	y Year 2010	3. Time of I	
Exami	ner	4a. Facility Name (If not institution,				4b. City, Town, o		of Death			County of Deatl	1	
Funeral Director		220-40-2295	ursing & Re 6. Sex 1 M 2 F 7. Ag	hab Co e (In yrs. la: 66	enter st birthday) Yrs.	Frost If Under 1 Year Months Days		24 Hrs. 8. Min.	Date of Birth (Month, Day October	1	11egany 9. Birth Co. Ma	nplace (State or untry) ryland	Foreign
Maryland -f show fled at	tor	Usual Residence of Decedent 10a. State 10b. County	any	10c. City,	Town or Lo	ocation						10d. Inside City	
h with the 23a or 28a st be noti	al Director		Vational Highway	7		10f. Zip Code 21501-				U.S	izen of What Co .A.	untry?	
ING Z1Z13-UU36 be filed within 72 hours after death with the Maryland hal Hygiene. dother then "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3 □ Widowed 4 ▼ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	,		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	lispanic Or an, Mexica Specify:		Yes or No- an, etc.)		14. Race - Ame Black, White Specify: WI	e, etc.	
TZTD-UU36 within 72 hours af ene. than "natural", or the Medical Exami	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	s Education t grade completed) College (1-4or	5+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retire ekeeping	oation during mos d)	st of working			ind of Business/ spital	ndustry	
= 0 = 0 %	To Be Co	17. Father's Name (First, Middle, I John Ferree	_ast)				Bett	er's Name <i>(Fi</i> y Sturtz					
Mary nd 2 sho lth and 27 Is ma		19a. Informant's Name/Relationsh Ronda Fuller	ip (Type. Print) daughter			ng Address (Street Arizona Ave.	and Numb	er or Rural R LaVale		er, City	or Town, State, 2 Maryland	Tip Code) 21502	2-
ESILIMOTE, MATYIST permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ea		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 ☐ Removal from State	CO	metery, cre	osition (Name of matory or other pla		Date			ocation - City or	Town, State Maryland	
baltile permit. F Department Importar any injur		21. Signature of Funeral Service L		1	2	2. Name and Addre Durst Fune		•	st Ave.	Fros	stburg, MD	21532	
Physician /Medical Examiner ial-transit		23a. Part . Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. End S Due to (or as	a conseque	ence of):	ter the mode of dyi		s cardiac or re	espiratory ar	rest,		Approximate Interval Bett Onset and I	ween Death
I HECOrds, P.O. BOX 68/60, The law requires that the death certificate be ex tee has been signed by the attending physician and page 2 should be detached for use as the burial	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	d	2 Fetal	death 3	□Ectopic pregnanc	ру				23d. Date of de Month		Year
s that the d ned by the	by Physi	9 ☐ Unknown Part II. Other significant condition	9□Unknown			und <i>e</i> rlyin g cause gi	ven in Part	I.	23 <i>e</i> . Did t	obacco	use contribute to		
Ords require een sig nould b									1 🗆 '	Yes 2	2 No 3 P		Jnknown
	Completed								24a. Was auto perfo 1 Yes		prior to death?	utopsy findings completion of c	available ause of
VITAI sician: T s certificat lirector, pa	o Be	25. Was case referred to medical examiner? 1 □ Yes 2 No	Hospital: 1 □ Inpati			ent 3 DOA Ot		e of Death (C			6 □Other (Spe	ecify)	
DIVISION OF VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificicompletely filled in by the funeral director,	ation: To	27. Manner of Death 1. Natural 5 Pending 2 Accident investig	28a. Date of Inj (Month, Da	ury	28b. Time Injury	of 28c. Inju		280			ury occurred		
UNVISION To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Certification:	3 Suicide 6 Could r 4 Homicide determ	ined 28e. Place of in building, e	etc. (Specify)	treet, factory, office			City or To	wn, Sta			nber,
the Hospi iin 24 hou the Funer npletely fill	Medical	(Check only 2 Medical one)	g Physician: To the besi Examiner: On the basis and manner s	of auaminati	ion and/or i	avactication in my	opinion de	aath accurred	at the time	data a	nd place, and du	a to the causel	s)
To To To	Σ	29b. Signature and title of certified	Allin	MI	7	29c. Licen DC , Print) USh Ro	0055	325		A . D	PH 20	2010	
nes		30. Name and address of person	who completed cause of	death (Item	23a) (Type	Ish Ro	1 G	unter	Ixm	1	4021	502	J
	tate trar	31. Date filed (Month, Day, Year) APR 2 2 201	32. Regist	trar's Signat	to arks	1							
DHMH 17 Rev 1	_	HEU MW COL	- photon	10. 19	7								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 19, Day 2010 **Physician** Ditto 12:16 р м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Glen Meadows Nursing Home Glen Arm Baltimore 8. Date of Birth (Month, Day, May 15, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. West Virginia 1920 579-12-4307 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f sho 1 ☐ Yes 2 No Director Maryland Baltimore Glen Arm 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 11630 Glen Arm Road 21057 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No Specify: þ Specify: White 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond Dawson Elsie Mesner 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any injury or other trau Janice D. Schwartz/Daughter 8603 Discovery Blvd., Walkersville, MD 21793 April 2010 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park Rockville.Maryland 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Li 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, Examiner If any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last executed and burial-tra Box 68760.+ Due to (or as a consequence of) requires that the death certificate be Physician/Medical as attending IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy for Month Day Year Pregnant at time of death 5 Other (specify) Ö the 4 signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. id tobacco use contribute to the cause of death? Division of Vital Records, ş pe 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed. Yes 2 No 1 □ Yes 1 ☐ Yes 2 ☐ No director. se referred to nedical 26. Place of Death (Check only one) ner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) es 2 🗌 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? Hospital or Attending av. Year) 1 Natural 5 Pending ionth. (Joura en 353 2010 ull 1 ☐ Yes 2 🗹 No 2 Accident investigation after death Director; Place of Injury - At home 3 Suicide 6 Could not be At home, farm, street, factory, office 8f. Location (Street and Number or Rural Route City or Town, State) 4 Homicide 11630 Assisted renam hd. To the Hospital or within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, dean occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or nestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2010

Registrar

30. Name and address of person who completed cause of

Year)

, Day,

21

31. Date filed (Month

ath (Item 23a) (Type, Print)

6701

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Isabel Damewood April 14, 2010 09:18 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frostburg Village Nursing Care Center Allegany Frostburg 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Min 1 □ M 2 🛣 F Hours 212-01-9641 Yrs. Director March 27, 1911 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ital Marile Exminant has not filed at any pings. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Allegany 1 Yes 2 □ No Maryland Midlothian 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19707 Old Midlothian Road 21543-U.S.A. Funeral P.O. Box 371 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No þ Specify. 3 ₩Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Floor boss clothing manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Dudley Pearl Bennett ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Damewood son P.O. Box 374 Midlothian Maryland 21543-20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ⊯ Burial 2 ☐ Cremation 3 ☐ Removal from State Frostburg Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) April 16, 2010 Frostburg Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CORONARY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à DEMENTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 24 No 2 □ No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural n 24 hours after death.

e Funeral Director: Af 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 hor To the Fune completely fi (Check only the 29b. Signature and title of certifier 0 29c. License number 3 Helhu

State Registrar

31. Date filed (Month, Day, Year)

1Xm

DHMH 17 Rev 1/2001

Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARIT SILLY M.D. 935 Bishop Walsh DR.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 900 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington Fort vashington Reha ince Nursina 7. Age (n yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 💢 F Months Days Hours Min. Month, Day, Y Director Usual Residence of Decedent 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho: 10a. State 10b. County 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at Completed by Funeral Director 10d. Inside City Limits 1 Yes 2 No UTEO Y DES 10f. Zip Code 10g. Citizen of What Country? 20744 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Black Specify: 3 - Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Jursing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 NORMAN VEE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ND-26744 Indian 394 GIMMAHUM 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 12010 STAFFORD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility podbridge 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last the attending physician and thed for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year cate has been signed by the a page 2 should be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown . Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy eral Director: After this certificate I filled in by the funeral director, pag 1 Yes Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes Accident
Suicide Investigation 6 Could not be 2 No Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide hours after City or Town, State) within 24 hours a

To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Gertifying Nurse Practioners To the best of my knowle 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of pers on who completed ause of death (Item 23a) (Type, Print) 11701 LIVINGSTON RD FORT WASHINGTON MD. 20744 M·D 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State	of Marylan		irtment of F tificate of D		Mental Hy	200	110	11.080		
			Registrar 1. Decedent's Name (First, Middle,	Last)		Cer	uncate of L	Jeaur	2. Date of De	Reg. No.	JIU	3. Time of Death		
PI	hysicia Medic		William Martin	Ebaugh					Month 4	1 ² 4 ^{ay}	2010	4:20.: PM		
E	Examin	er	4a. Facility Name (if not institution,	-	nber)		4b. City, Town, or		h		ty of Death			
Fı	uneral		14405 Jarvis Av 5. Social Security Number	6. Sex	7. Age (In yrs. Ia	st birthday)	Ocean If Under 1 Year	If Under 24 Hrs		th	ester 9. Birthp	place (State or Foreign		
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pu	show	or	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	ation				1	0d. Inside City Limits		
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h the	a or 2	al Di	10e. Street and Number				10f. Zip Code			10g. Citizen o	f What Coun	itry?		
ath wit	ms 2.	Funeral Director	14405 Jarvis Av		edent Ever in U.S	13 14	218		necify Yes or No-	USA		an Indian		
XIXID-UU30 within 72 hours after de: giene,	ıral", or ite Examiner	by	1 ☐ Never Married 2 ☒ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Fo	rces? 2 No e		/as Decedent of Hi Yes, specify Cuba ☐ Yes 2 🖔 No		to Rican, etc.)	Speci	ace - Americ ack, White, e			
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r yland uld be filed d Mental Hy	narke	10	William Ebaugh			T			<u>irginia</u>					
Man 12 shou lith and	27 is r r traur		19a. Informant's Name/Relationshi Anna Ebaugh / w			1	g Address (Street a					Code)		
of Hea	f item r othe		20a. Method of Disposition		20b. Pl	ace of Dispos	sition (Name of atory or other place		Date	20c. Location		wn, State		
Dalumore, bermit. Page 1 and Department of Hea	tant: I jury o		1 ☐ Burial 2 ☒ Cremation 3 4 ☐ Donation 5 ☐ Other (Sc	necify)	Jiaie	e Henl	open Cre	m. 4/15		Frank				
Dal permit Depar	The purpose of the pu													
.*			23a. Part 1. Friter the disease, or of shock, or heart failure. List on Immediate Cause (Final	complications that only one cause on ea	caused the death			g, such as cardiad	or respiratory ar	rest,		Approximate Interval Between Onset and Death		
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death ce	been signed by the attending I should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live	come of pregnar Birth 2 □ Fetal nant at time of d	death 3	Ectopic pregnand Other (specify)	у		1	ate of delive Nonth	ery Day Year		
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jan:	ertificat ctor, p		25. Was case referred to medical examiner?				26. Pla	ace of Death (Che	1 L Yes	2 100	1 Yes	2 L N0		
Physic	this ce al dire	은	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1	Inpatient 2 1	R/Outpatient		4 L Nursing F	Home 5 Resi					
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pital o	eral Di		00-0-15-	III S					V					
the Hospital or Attending Physician: The law requires that the death certificate be executed in 24 hours after death.	To the Funeral Director: After this completed filled in by the funeral director.	Medical	(Check 2 \(\sum \) Medical Ex	Physician: To the base aminer: On the base Nurse Practioner:	is of examination	and/or investi	gation, in my opinic	n, death occurred	at the time, date a	and place, and c	lue to the cau	ise(s) and manner stated.		
To th	comit de		29b. Signature and title of certifier				29c. License	number		29d. Date sign	ed (Month, L	Day, Year)		
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BA	12+1		30. Name and address of person wi	NO nic	e of death (Item	23a) (Type, Pr	wed	Borlin,	815 am	111				
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 04 20/D 0150 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Location of Death 4c. County of Death Examiner General Hospital AC Worldste If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖸 F Months Days Hours Min. 144-07-6465 96 Director /7/1914 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it s [worker] Expension must be rediffed at 1 □Yes 2√□No Director MD Worcester Whaleyville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12828 Murray Rd. Funeral 21872 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 □ Yes 2 □ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No Specify: þ Specify 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Bus Service <u>Bookkeeper</u> and Mental Hygi is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ella Estvanik George Hovan 0 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health a Important: If item 27 is any Injury or other trau Ronald W. Freund / 12828 Murray Rd., Whaleville, MD 21872 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Somerville Cemetery 4/20/2010 Somerville, NJ 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Li 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 00515 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examir Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 5 ☐ Other (specify) signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has page 2 s autopsy certificate perform 1 □Yes 2 No Division of Vital 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Papatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death o the Hospital or Attending Plithin 24 hours after death.
o the Funeral Director: After thempletely filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 0 4/16/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) way Drive Belin maryland 21811 BA3 97-33 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

000104/10/2010

4161160120

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Agnes Cecelia Festerman April 22, 2010 07:15 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frostburg Village Nusing Care Center Frostburg Allegany 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign
Country) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 ☐ M 2 😿 F 215-16-4949 Director 86 November 17, 1923 Maryland Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Maryland Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 89 Armstrong Street ŏ 23a 21532-U.S.A. Funeral items ; 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 0 Specify: White 1 ☐Yes 2 X No Specify. 2 3X Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than filed withir Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 0 homemaker homemaker marked other ulth and Mental Hv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Klosterman Margaret Lavin ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a James Craze, Jr. grandson 267 Laguna Circle Severna Park Maryland 21146-20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c Location - City or Town, State Pages 1 permit. Pages
Department of
Important: If it
any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory April 25, 2010 Cumberland Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 121 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Congestive 2 months disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if an, leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) P.O. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy page perform certificate 2 X No 1 ☐ Yes 1 □Yes 2 K No Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2**≸**INo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After or Attending 1 Natural 2 ☐ Accident 5 Pending I hours after death.
uneral Director: Af 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 00055325 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd Camberland MP2/502 925 WONSOCK MD BIShop SHIN €2. Registrar's Signature 31. Date filed (Month, Day, Year, State 26 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 7:00 pm Elyce Fern Fisher 2010 Apri Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. Cify, Town, or Location of Death 4c. County of Death Prince George's 507 Greenhill Avenue Laurel Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** March 19 1 □ M 2 🗓 F Months Days Hours Min Director 215-62-9224 1968 Washington. Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🗶 No Maruland Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 507 Greenhill Avenue 20707 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or δ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify. Completed 3 Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany Injury or other traumatic event, the Mediral 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) None None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eugene Fisher Adrienne Goldstein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eugene Fisher - Father 9912 Bluegrass Road, Potomac, Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🕱 Burial 2 🗆 Cremation 3 🗆 Removal from State Beth El Memorial Pk.: 04/19/2010|Randallstown, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinildi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Failure to Thrive disease or condition uear Medical resulting in death) Examiner Cerebral Palsu 42 years Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examin cause. Enter Underlying sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death s been signed by the should be detached 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed? Yes 2 X No 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 🗓 No 은 1 Inpatient 2 ER/Outpatient 3 IDOA this 4 Nursing Home 5 X Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 1 X Natural 5 Pending nours after death.

neral Director: Aff
I filled in by the fur Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral E Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 29b. Signature and the of certifier D0047707 April 19. 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rita Pabla, MD, 13621 Baltimore Avenue, Laurel, Maryland 20707 2 1 2010

State Registrar

31. Date filed (//

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 10:30 AM Lucille Yvonne Guyer-Routhier April 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frostburg Village Nursing Home Frostburg Allegany If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 😾 F 84 06/06/1925 009-12-8635 Vermont Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Expression to the synthesis 1 X Yes 2 ☐ No Director MD Allegany Frostburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene.
Important: If them 27 is marked other than "--any injury or other traumetonce. 21532 USA 99 Mt. Pleasant Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give X
Year or Dates: Black, White, etc 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: 2 White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Hospital 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Couture Adelard Guyer Trene 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 99 Mt. Pleasant Street, Frostburg, MD 21532 Marc Routhier / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State Cumberland Crematory 04/29/2010 4 ☐ Donation 5 ☐ Other (Specify) Cumberland, MD 21. sign tur, of Funeral Service I 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 6months Endstage disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine law requires that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Vear 5 Other (specify) signed by the a d be detached f P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Š icate has been siç , page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy e Hospital or Attending Physician: The 24 hours after death.
2 Funeral Director: After this certificate hietely filled in by the funeral director, page 2 No 1 ☐ Yes Z No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical To the Hosp within 24 hor To the Fune completely fi (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD womorksh 00055325 ADH 28, 2010 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MRE Walsh Rd Cumperland MD 21502 925 BIShop 32. Registrar's Signature WONSOCK SHIN

DHMH 17 Rev 1/2001

Registrar

backs

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 April 16. 10:40 a Patricia Loretta Gannon Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mon topmery Rockville Montgomery Hospice-Casey House If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 85 Yrs 579-20-4963 Months Davs Hours october 10, 1924 Washington, DC Director Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified Maryland Montgomery Kensington 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral USA 20895 9710 Summit Avenue 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11 Marital Status Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc ð 1 X Never Married 2 Married ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☐ No Specify: If Yes Give 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Federal Government Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edith May Elam Joseph Callahan Gannon 19a. Informant's Name/Relationship (Type, Print) Bb. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9710 Summit Avenue, Kensington, MD 20895 Patricia G. Garayta/Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mount Olivet Cemetery April 20 2010 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Washington, DC injury 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service of ensee ²² Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 Nuhara L Lako Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Approximate Interval Between Onset and Death Immediate Cause (Final Malignant Neoplasm of Oral Cavity Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. E to Ur Jerying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE use a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed? Yes 2 No certificate 1 Yes 2 No director, Be B 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Tother (Specify) 2 No ြု 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27 Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🗷 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide
Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D60634 April 14, 2010 el 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bindu Joseph, MD 1355 Piccard Drive, Rockville, MD 20850

State

Registrar

31. Date filed (Manth, Day, Year) APR 2 1 2010

parke

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Month April Dorothy Hankin Golomb Medical 6:42 ам 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5450 Whitley Park Terrace, Apt. #804 Bethesda Montgomery **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Director 1 M 2 W F 9. Birthplace (State or Foreign 215-16-0504 Country) Maryland Yrs. Hours Min. 88 Usual Residence of Decedent or 28a-f show filed within 72 hours after death with the Maryland 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State Funeral Director 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Montgomeru Bethesda 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5450 Whitley Park Terrace, Apt. #804 20814 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ Black, White, etc. 3 X Widowed 4 □ Divorced Completed 1 Yes 2 No Year or Dates 15. Decedent's Education (Specify only highest grade completed) White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Be Own Home 17. Father's Name (First, Middle, Last) n and Mental I permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatte eve 18. Mother's Name (First, Middle, Maiden Surname) 2 Samuel Hankin Freda Gosh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arlene G. Gerst - Daughter 11413 Frances Green Drive, N. Potomac, MD 20878 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 🔀 Burial 2 🗌 Cremation 3 🔀 Removal from State 4 Donation 5 Other (Specify) King David Mem. Grdns 04/20/2010 | Falls Church, VA 21. Signature of Funeral Service Licensee Mo #1070 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. <u>11800 New Hampshire Ave., Silver Spring, MĎ 20904</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final dis e or condition Ph, sician Interval Between Gastrinoma Onset and Death Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 5 Other (specify) ___ 23d. Date of delivery After this certificate has been signed by the funeral director, page 2 should be detached Month Day Division of Vital Records, P.O. Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director; r 25. Was case referred to medical Yes 2 X N Be 26. Place of Death (Check only one) Hospital Certificate: To 1 Yes 2 X No Other: 4 Nursing Home 5 XX Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No 1 X Natural 28d. Describe how injury occurred 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) D26259 April 19, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ava A. Kaufman, MPH, 8218 Wisconsin Avenue, Ste 103, Bethesda, Maryland 20814 MD, 31. Date filed (Month, Day, Year) State 32. Registrar's Signature 2 1 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2<u>010</u> Greshko April Physician/ Helen 28 10:40A. M Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Silver Spring Montgomery 3114 Gracefield Road, WC202 If Under 1 Year If Under 24 Hrs Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Min. 1 M 2 X F Hours Jan. 30, Year 922 Pennsylvania 169-14-9657 88 Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director event, the Medical Examiner must be notified 1 🗆 Yes 2 🔀 No Silver Spring Maryland Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ò 23a by Funeral 3114 Gracefield Road, WC202 20904 United States items permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔼 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give Completed 3 XWidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Housewife own home Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) ဂ္ Michael Rock Helen Balyo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1802 Woodrail Drive Millersville, Maryland 21108 Thomas Greshko -son 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of gemetery, crematory or other place) 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 5/1/2010 Calvary Cemetery Drums, Pennsylvania 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License Donald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, 4/3 eld Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physiciani Pancreatic Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or irrijury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
g ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Day 1 Yes 2 L sate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Coronary Artery Disease with history of cardiac stents; 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗡 Unknown Hypothyroidism 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 X No 1 Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2X No 4 Nursing Home 5 X Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA after death.

Director: After this completed filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) XNatural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide
Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours 1 ី Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar achelle

MAY 05

31. Date filed (Month, Day, Year)

lehro

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

DIL

D44156

Silver Spring

April 28, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Physician/ HILES Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner LAND 7. Age (In yrs. last birthday) 8, Date of Birth 9. Birthplace (State or Foreign Funeral 1 M M 2 🗆 F (Month, Day, Year) 9-17-1928 Country) Director or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits the Medical Examiner must be notified at Director BEDFORD HYNDMAN 1 Yes 2 X No 10e. Street and Number 10g. Citizen of What Country? Funeral GOOSEBERRY items 23a USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 1 Yes 2 No Black, White, etc. "natural", or þ 1 Never Married 2 Narried Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1948 - 71 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) id Mental Hygiene. marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Funeral Director's Funeral Home Assistant injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file ment of Health and Mental I ant: If item 27 is marked o CARRIE MARION HILES HARD 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M90 GOOSEBERRY RO HUNDMAN PA 0 HILES/Wife JOANNA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Department of I 1 X Burial 2 Cremation 3 Removal from State 4-24-2010 HYNDMAN, PA HYNDMAN CEMETERY 4 Donation 5 Other (Specify) 22. Name and Address of Facility HARVEY H. ZEIGLER 15545 21. Signature of Funeral Service License FUNERAL HOME INC 169 Clarence ST HUNDMAN 23a. Part 1. Inter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hepato hydrothorax Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner 70 that the death certificate be executed Failure Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 X N 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A'
completed filled in by the fu 1 Yes 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 29d. Date signed (Month, Day, Year) Audalan En Kest 4,21,10 10/1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) willow brook road, Cumberland, MD 21502 Ardulan Enkeshafi 12500

DHMH 17 Rev 7/2009

Registra

68760

Box (

P.O.

Records,

Division of Vital

Barks

32. Registrar's Signature

To Be Completed by Funeral Director

Examiner

Physician/Medical

Be Completed by

Physician/

Medical

Examiner

Funeral

Director

Registrar					artment of I rtificate of I			g. No. 2 1 1	1 1408
1. Decedent's Name		^	1.1	1.405	-7		2. Date of Death Month	100	3. Time of Death
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	ot institution, give stre					r Location of Deat		4c. County of Dea	
	CF MARYLAND					RE, MD		BALTIMOR	
. Social Security Nur 213 - 13 -	6372 10	М 2 🕱 F	23	st birthday) Yrs.	Months Days	If Under 24 Hrs Hours Min.		Voor! Co	thplace (State or Foreign Kyland
Jsual Residence of D	Decedent 10b. County		10c, City	, Town or Lo	cation				10d. Inside City Limits
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0e. Street and Numb		•			10f. Zip Code		10	Og. Citizen of What Co	Λ
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1. Marital Status		2. Was Decedent E	ver in U.S	. 13.1	Was Decedent of H		pecify Yes or No-	14. Race - Ame	erican Indian.
1 X Never Marrie		Armed Forces? 1 Yes 2		1	If Yes, specify Cuba	an, Mexican, Puer	to Rican, etc.)	Black, Whit	
3 Widowed 4		If Yes, Give Year or Dates.			1 ☐ Yes 2 💢 No	Specify:		Specify:	White
/0.000	15. Decedent's Educ ify only highest grade	ation			dent's Usual Occup		dina	16b. Kind of Business	
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Richard	<u> </u>		Haine	s		Becci		ııaı	USUCK
	ne/Relationship (Type				-			City or Town, State, Zi	
	tsock / M	other				Street		and, Maryl	
0a. Method of Dispo 1 ☐ Burial 2 🖸	osition ∄Cremation 3 □ Re	emoval from State	CE	metery, crer	osition (Name of matory or other plac	ce)		20c. Location - City or	
4 Donation	5 Other (Specify)		Cum		nd Cremat			Cumberlan	,
21. Signature of Fund	eral Serflice Licensee	amo						ly Funeral rland, MD	
23a. Part 1. Enter the	e disease, or complic failure. List only one	ations that caused	the death	. Do not ent	er the mode of dyir	ng, such as cardia	c or respiratory arres	t,	Approximate Interval Between
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resulting in death)	a . a.	Due to (or as a			Tree in the same	((0)0)		· ·	
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resulting in death) La	ast	Due to (or as a		ence of):	,				
	d.	AML	-						
F FEMALE:									
23b. Was decedent p	regnant	c. If yes, outcome 1 Live Birth			Ectopic pregnan	су		23d. Date of de	
		4 Pregnant a	t time of d	eath 5	Other (specify)			Month	Day Year
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in the past 12 m 1 ☐ Yes 2 ☐ 9 🕱 Unknown	cant conditions conti	ributing to death b							
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in the past 12 m 1 ☐ Yes 2 ☐ 9 🎛 Unknown Part II. Other signific		ributing to death b			26 P	lace of Death /Chr	24a. Was an autops perform	24b. Were au prior to death?	utopsy findings available completion of cause of
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in the past 12 m 1	d to medical	spital:	v I		nt 3 DOA Oth	er: 4 Nursing	24a. Was an autops; perform 1 Yes 2 eck only one)	24b. Were at prior to death? No 1 Ye	utopsy findings available completion of cause of s 2 No

25. Was case r examiner? 1 \square Yes Medical Certificate: To 27. Manner of 1 Natura
2 Accid
3 Suicid
4 Homio 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Cobert, MD Resident Physician

1497980510

4/27/10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22 Greene St., Baltimore, MD Emilie Cobert, MD 21201

State Registrar 31. Date filed (Month, Day, Year)
APR 29

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Fundamental Periff Poor Registrary 23-10/Amental 7. Periff Poor Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ APRIT. 2010 AT. TOSON HILLIARD 2040 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SOUTHERN MARYLAND HOSPITAL PRINCE GEORGES CLINTON 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) Funeral (Month, Day, Days Hours Min Country) **Director** 77 NC 67 243-50-1983 28a-f show 10a State 10b. County Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Prince Georges Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 8514 James St. 20772 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. o, 1 Never Married 2 Married Completed by Yes 2 No f Yes, Give 53 **–** 1955 1 Yes 2X No Specify: "natural". Specify: 3 Widowed 4 X Divorced Black Year or Dates. injury or other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Cartography Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental မ Hardie Hilliard Annie Ricks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Hilliard - Daughter 8514 James St. Upper Marlboro, MD. 20772 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-22-2010 Maryland Veterans Cheltenham, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home of Maryland ictar 4308 Suitland Rd. Suitland, MD. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS SYNDROMS Physician/ disease or condition Medical resulting in death) Examiner LEUKEM1A LYMPHOCYTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir Cause (Disease or linjury that initiated events 1 HROMBOCY TOPENIA resulting in death) Last Due to (or as a consequence of) burial Physician/Medical that the death certificate be IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year 4 ☐ Pregnant at time of death g ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No ☐ Yes 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending work?
1 Yes 2 No injury Natural 5 Pending Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: In the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signa death (Item 23a) (Type, Print) rson who completed caus ROAD. CLINTON 7503 SURRATTS 0 32. Registra 's Sign 31. Date filed (Month. Day, Year State 2 2 2010

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

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Box

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Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ $0^{\text{Month}}_{4}15-20^{\text{Day}}_{1}0$ ANNIE ROSE JOHNSON 12:10PM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Southern Maryland Hospital Clinton 9. Birthplace (State or Foreign Country) USA Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Hours 1 ☐ M 2X☐ F 04-03-1947 Director 577-66-6107 63 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 X Yes 2 No Maryland Prince George District Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3243 Forest Run Drive 20747 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. X Never Married 2 ☐ Married þ 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Black "natural" Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 5 + Elementary/Seconday (0-12) Dist. of Col. Gov't Counselor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Matilda Sykes William Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9907 Brookhaven Lane, Upper Marlboro, Teneshia Alston/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🏋 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Cedar Hill Cem. 04-30-2010 SUitland, Maryland 20746 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mary Hedgman Cedar Hill FH,4111 PA Ave.,Suitland,MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final CIRRHOSIS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Day signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by SEPTICEMIA Hospital or Attending Physician: The law requires 24 hours after death. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown FAILURE CONGESTIVE 24b. Were autopsy findings available prior to completion of cause of death? HEART 24a. Was an autopsy DISEASE performed CHRONIC STAGE KIDNEY certificate I 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ၉ 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Funeral Director: After this sted filled in by the funeral dii 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) D0064986 416/2010 MD Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar Signature State APR 2 2 2010 Registrar

Baltimore, Maryland 21215-0036

Box 68760

Records, P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2010 A M Helmuth Erik Jorgensen April 10:11 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery Social Security Numbe If Under 1 Year If Under 24 Hrs Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) une 19, 1 🗙 M 2 🗆 F Months Days Hours Country) 82 Director Yrs 100-20-2779 Denmark June Usual Residence of Decedent or 28a-f show e notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 No Montgomery Chevy Chase MD 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? ms 23a or Funeral 8100 Connecticut Ave. Apt 20815 ıral", or items 2 I Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 X Married Completed by 1 Yes 2 If Yes, Give Baltimore, Maryland 21215-0036 res, Give Year or Dates. 1945-46 1 Yes 2 No Specify Specify: White "natural", 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than 'iury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) 5+ Professor Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Edmund Jorgensen Anna Nielsen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cecelia M. Jorgensen /Wife 8100 Connecticut Ave. Apt.1212 Chevy Chase, MD 20815 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Aprilate 18 permit. Page 1 Department of Important: If it 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Alexandria, Virginia MetropolitanCrematory 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spr 21. Signature of Funeral Service Licensee m Spring,MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Years Immediate Cause (Final Physician/ Atherosclerotic Cardiovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions. Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence oi) RELIGITA E. JORGENSEN To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and that initiated events Due to (or as a consequence of) resulting in death) Last has been signed by the attending physician e 2 should be detached for use as the burial Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 2 No g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Bilateral Pneumonia, Parkinsonian Syndrome, director, page 2 should be 1 🗌 Yes 2x No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Congestive Heart Failure, COPD autopsy performed? Yes 2 \(\int\) No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🛛 🗓 No 1 Anpatient 2 ER/Outpatient 3 DOA the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending work? M 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined

State Registrar

Medical

29a. Certifie

only one

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

30. Name and address of person was Rajan Shyam sunder

Georgia Avenue,

APR 21 2010

and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Suite 117, Silver Spring, MD 20902

Park

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) April, 12, 2010

29c. License numbe

D53367

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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_			Registrar	Cer	tificate of D	eath			Reg. No.	4 U I	U	1 54	UJJ
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	Medic		CHARLES CLIFTON KELLY JR. 4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of F		PLIT _		County of		110:43	o a ™
	Examin	er	Holy Cross Hospital		Silver					lontg		rv	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday)	If Under 1 Year	If Under 24	Hrs. 8.	Date of Birt	h	T	a. Birthr	place (State o	or Foreign
	Director		579-46-7079 1 ^{1⊠M 2 □ F} 73	Yrs.	Months Days	Hours	Min. Se	(Month, Day	193	6	Coun	DC DC	
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	or 282 notif	Director	MD Montgomery Silv	er S	pring 10f. Zip Code *				10a Citi	zen of Wh	at Cour	ntry?	
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	eath v	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	13. \	Vas Decedent of Hi f Yes, specify Cuba	spanic Origin	? (Specify	Yes or No-	Т	14. Race -	Americ	an Indian,	
õ	fter de , or if	by	1 ☐ Never Married 2 ☒ Married Armed Forces? 1 ☐ Yes 2 ☒ No	- 1	t Yes, specify Cuba		uerto Rica	in, etc.)			White,	etc.	
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yland	l be fi denta irked tic ev	To	Charles Clifton Kelly, Sr.			Viola	Rob:	inson					
Mary	should and N is ma		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street a								
Σ.	nd 2 sealth m 27		Elsie Kelly - Wife		Addison	Rd. So	uth i	#1Dist				_	.0747
ore	e 1 al t of H If itel		20a. Method of Disposition 20b. Plac 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State cerr	e of Dispo etery, cren	sition (Name of natory or other plac	:e)	Date	·	20c. Lo	cation - C	ity or To	own, State	
saltimore,	t. Pag tmeni tant: tjury o		4 ☐ Donation 5 ☐ Other (Specify) Metr		itan Crem					andr		VA.	
g	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee		Name and Address arshall s 308 Suitl							6	
			23a. Part 1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line.									Approxima Interval Be	
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2	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical	d. Alzheimer's	Demen	tia						+	yrs	
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	<u>.</u>		30. Name and address of person who completed cause of death (Item 2:	AD Ba) (Type D	Print)	04548	5		- 1	((((d- (-10	
	10		Barbara Supanich, RSM, MD 1580	Fore	st Glenn	Rd.	Silve	r Spr	ing,	MD			
	Sta Registra		31. Date filed (Month, Day, Year) APR 2 2 2010 APR 2 2 2010 APR 2 32. Registrar's Signatur	Red									
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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010° April Fred Kramer 2:11pM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring 605 Piping Rock Drive 9. Birthplace (State or Foreign Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days 1 X M 2 D F Hours Washington. Director 84 578-24-3301 D.C Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🕅 No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20905 U.S.A. 605 Piping Rock Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Divorced 4 Divorced White WWII 15. Decedent's Education 16b. Kind of Business Industry 16a, Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72., h and Mental Hygiene.
7 is marked other than "r D.C. Department of Elementary/Seconday (0-12) College (1-4 or 5+) Assistant Director Recreation Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Maru Eisenberg David Kramer and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 605 Piping Rock Drive, Silver Spring, MD 20905 Anna Kramer - Wife or other tem 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 s Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State 04/22/2010 Silver Spring, MD 4 Donation 5 Other (Specify) Gate of Heaven Cem. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Annealane Warker 1232 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Parkinson's Disease Y e<u>ars</u> disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗓 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Dementia autopsy performed? Yes 2 N Benian Prostatic Huperplasia Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one, Be Other: 2 X No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completed filled in by the fi Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) Melerd April 20, 2010 D0057630 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Anuradha Arun, Mi 31. Date filed (Month, Day, Year) APR 21 2010 10301 Georgia Avenue,

#209, Silver Spring, Maryland 20902

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Mar	-	Certificate			Reg.	2010	14095
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أمسد	e		Western MD Regio				MBER	<u> </u>		AIIEGA	
	Funeral Director		212-32-0101	ex 7. Age (iii	n yrs. last birtha 4 Yr	Months	Days Hou	urs Min. (Mo	te of Birth o <i>nth, D</i> ay, Yea /06/193	r) Cot	hplace (State or Foreign Intry) yland
	and show lat	o	Usual Residence of Decedent 10a. State 10b. County	10	0c. City, Town o	r Location					10d. Inside City Limits
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	s 23a or	Funeral D	10e. Street and Number 13406 Pershing	Street, SW		10f. Zip	^{Code} 21502		10g.	Citizen of What Co	untry?
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	호	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Evel Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.		If Yes, speci	ent of Hispanic ify Cuban, Mex 2 No Spe	c Origin? (Specify Yes xican, Puerto Rican, e ecify:	s or No- etc.)	14. Race - Amer Black, White Specify:	
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Baltimore, Maryland 21215-0036	d 2 should alth and N 1 27 is ma er trauma		19a. Informant's Name/Relationship (7) Debra A. Wolford					umber or Rural Route Street, S			
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	Medical		disease or condition resulting in death)	a. Due to (or a a co		9/ 6/	ecd				1day
	Examiner	ē	Sequentially list conditions,	b. Due to for as a or	(X-54)-0.00 (2.104)						
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to to, as a or	orisequence on.						
_	cate be executed physician and the burial-transit	ial Ex	resulting in death) Last	Due to (or as a co	onsequence of):						
3760	ficate b g physi as the b	Medical		d							
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours afferd eath. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of p 1 Live Birth 2 4 Pregnant at tir 9 Unknown	Fetal death	3 Ectopic p 5 Other (spe				23d. Date of deli Month	very Day Year
P.0	that the	by Ph	Part II. Other significant conditions of	-	,	, ,	0		Be. Did tobacc	o use contribute to	the cause of death?
rds,	equires neen sig	eted	Diubetes mello hypothy willi	rus, hype/To	nsion A	ypolip)	denia			-	obably 4 Unknown
eco	e has t	Completed	- Nypothy wishi	in, ather.	Sclentle	Colon	vy art		la. Was an autopsy performed	prior to o death?	opsy findings available ompletion of cause of
ᄪ	Physician: The law this certificate has al director, page 2 g	Be C	25. Was case referred to medical examiner?	Hamilah	.		1	Death (Check only or	☐ Yes 2 🚰 ne)	No. I Yes	2 No
Ž	Physion this of the rall direction	은	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Inpatient 28a. Date of injury	2 ER/Outp		Other: 4 [Nursing Home 5	Residence		fy)
ono	ending sath. or: Afte he fune	Certificate:	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Ye	ear) inju	ry M	work?	_	out the state of the	jary occurred	
Divisi	ial or Att		3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury building, etc. (S		, street, factory,	office		cation (Street and or Town, Sta	and Number or Run ite)	al Route Number,
_	he Hospit in 24 hour he Funera ipleted fill	Medical	(Check 2 L Medical Exami	sician: To the best of my ner: On the basis of exam se Practioner: To the bes	nination and/or in	vestigation, in m	ny opinion, dear	th occurred at the time	e, date and pla	ice, and due to the c	ause(s) and manner stated.
	North Vith		29b, Signature and title of certifier	1 Gerlin	ne?	29c.	D 214		29d. I	Date signed (Month	Day, Year)
	1/3/2		30. Name and address of person who o			ne, Print)	11019	00		pal 1	, 6-10
	Stal		31. Date filed (Month, Day, Year)	Devlin po	1 <i>D. ,</i> 20 Signature	Dougl	as Ave	nue, Lona	coning	, MD 215	39
	Registra		APR 19		m A.	park					
DH	4LI 17 Day 7/00	000		-		46					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 04 Month Physician/ 14^{Day} MAUDE LOUISE KILBY 2010 4:45 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death TALBOT WILLIAM HILL MANOR EASTON 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 - M 2 X F Months Days Hours Min. 1672871912 97 Director 578-26-7091 VA Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 X Yes 2 ☐ No TALBOT EASTON MD 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? Funeral 501 DUTCHMANS LANE 21601 UNITED STATES 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🗶 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give "natural", 3 Divorced Specify: WHITE Year or Dates other traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. other than " **FEDERAL** Elementary/Seconday (0-12) College (1-4 or 5+) CLERK **GOVERNMENT** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ൧ JOHN THOMAS KILBY DELLA FLOR HITT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .02 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 125 FIELDCROFT WAY, CENTREVILLE, MD HENRY KILBY/NEPHEW 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State FAIRVIEW CEMETERY 04/20/2010 CULPEPER, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME,
200 SOUTH HARRISON ST., EASTON, MD 21601 JOHN R. MERCER 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final a²ftysician/ disease or condition resulting in death) Medical Examiner Due to (or as a convequence of): Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to fr as a consequence of) Cause (Disease or iinjury physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death 5 Other (specify) Yes been signed by the a should be detached Unknown 9 I Inknown P.0. Part II. **Other** s**ignificant conditions**-contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Tes 2 → No 3 → Probably 4 → Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has ; page 2 s autopsy performed? Yes 2 ☐ No After this certificate funeral director, pag 2 🗌 No 1 Yes Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending Investigation 1 Yes 2 No Accident within 24 hours after death

To the Funeral Director: / 6 🗆 Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State

3

15 2010 Registrar

(Check

only one) 29b. Signature and title of

3 🗌

am

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

21601

29d. Date signed (Month, Day, Year)

29c. License number

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, After after death filled in by the within 24 hours a Hospitel

Baltimore, Maryland 21215-0036

State Registrar

completely

2

Medical

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

11151 31. Date filed (Month, Day,

29b. Signature and title of certifie

6 ☐ Could not be

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 5 2010

29c. License number

R146251

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

32. Registrar's Signature

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Drive Elknidge, Maryland

29d. Date signed (Month, Day, Year)

10-03151	
Justin Allen Loving	

lustin Allen Loving	1	- For State		and / Departr Certifi		Health and		lygiene	20	10 4098
Physician	1/	Registrar 1. Decedent's Name (First, Middl	le,Last)			204.7		2. Date of Dea Month 23		3. Time of Death
Medical Examin		Justin 4a. Facility Name (if not institutio	on, give street and nu	Loving	14	b. City, Town, or L	ocation of Deat	April 22 , 2	2010	1115 nrs
	H	2398 Telegraph Road	· -			North East			Cecil	
Funeral Director	- 1	5. Social Security Number 214 - 21- 3060	6. Sex	7. Age (In yrs. last b	1	If Under 1 Year Months Days	If Under 24Hr Hours Mir		. '	Foreign
	t	Usual Residence of Decedent	1 M 2 F		Yrs.			1911.0	11100	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. In Mental Hygiene, is marked other than "matural", or items 23a or 28a-f show any atte event, the Medical Examiner must be notified at once.	-1	10a. State 10b. County	il	10c. City, Tow		Deposi	+			10d. Inside City Limits 1 Yes 2 X No
Aarylanc 28a-f sh 1 at onc	Director	10e Street and Number			OI C	10f. Zip Code		1		t Country?
ith the N 23a or notified	<u>=</u>	1304 Th	eodore	Koad	142 18/00	Decedent of Hisp	1904	nosity Von an Ma		
death w	Funeral	1 Never Married 2 M			If Ye	s, specify Cuban,	Mexican, Puerto	Rican, etc.)		
irs after ural", c	a	3 Widowed 4 Div	orced If Yes, Give Yea or Dates:	ır .		Yes 2 X No s Usual Occupation		work done	Specify:	White ness/Industry
6 172 hou an "nat	Completed	Elementary/Secondary (0-12)			during mo	st of working life. [OO NOT use ret	tired)	2010 1115 11	
d within ygiene.	ě-	17. Father's Name (First, Middle,	Last)		<u> </u>		Drive B. Mother's Name			ou
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than c event, the Medica	e l	Not A	vailable				To	amara	Lovin	
	2	Barbara E. W		andmother	A. C	Box 15	514 P		_	
9 - F - 5		20a. Method of Disposition 1 Burial 2 X Cremation	n 3 Removal fr	om State	e of Disposit atory or othe	ion (Name of ceme er place)	etery,	Date		
Baltimore, permit. Pages 1 as Department of Hes Important: If ite injury or other tr	-	4 Donation 5 Other Sp 21. Signature of Funeral Seguice		Junitea						
	1	Vant I &	Du)	54	35 Chu	rchmai	ns Road,	Newar K	DE 19702
Physician /Medical		failure. List only one cause Immediate Cause (Final disease	on each line.	done and					est, snock, or near	Between Onset and
Examiner		or condition resulting in death)	Due to (or as a	consequence of):	OXYCOC	ione ince	AICALIC	<i>7</i> 11		
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b. Due to (or as a	consequence of):			· -			
eit d	EΙ	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence of):						
execui an and al-tra	3	X UNPENDED	d. X AMENDED	23a,27,28 , per ME	a-1,pe	T ME 090	3 3/26/	10 17		120 227
68760, certificate be ading physic se as the buri	Med	F FEMALE: 3b. Was decedent pregnant in th	23c. If yes,	outcome or pregnanc	у		_		100	The second second
box 68760, the death certificate be by the attending physic ched for use as the burner of the control of the co	Clar	past 12 months?	4 Pregn	irth ant at time of death	- =	ıl death 3 ∟ er <i>(Specify)</i>	_Ectopic pregna	ancy	Month	Day Year
that the death cred by the attendetached for us		1 Yes 2 No 9 Unk	ions contributing to		ing in the un	derlying cause giv	ren in Part I.	23e. Did to	obacco use contribu	ute to the cause of death?
ires that to tisined by the detac	5									Probably 4 Unknown
Division of Vital Records, P.O. Box 68760, ral or Attending Physician: The law requires that the death certificate be as er death. The rector After this certificate has been signed by the attending physiciled in by the funeral director, page 2 should be detached for use as the burification. To Bo Completed by Divisional Medical Completed by Divisi	completed							24a. Was autop perfo	sy pri	or to completion of cause of
tal Rec		25. Was case referred to medical				26.Place o	f Death (Check	1 ✓ Yes		
F Vital Physician: Physician: r this certifical director,	2	examiner? 1 Yes 2 No			Outpatient				ر ا	
nding Ph		27. Manner of Death 1 Natural 5 Pend		, Day,Year)	. Time of Inj	_ 1 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	at Work? s 2 X No	unk	how injury occurred	1
Division o spital or Attending nours as er deat neral litrector. After filled in by the fune	2	3 Suicide 6 X Could	d not be 28e. Place	e of Injury - At home,	farm, street	, factory, office bui	lding, etc.	28f. Location (\$	Street and Number	or Rural Route Number, City elegraph Rd
bou hou y fill		9a. Certifier Cartifular Ph	mined (Specify)	Found:			and place, and			
To the Ho within 24 I To the Fu completely	במונים			of examination and/or		on, in my opinion, o	death occurred a			
2	E 2	29b. Signature and title of certifie	ms			29c. License O.C.M				-
	3	30. Name and address of person	•						1	
		Ling Li, MD Assistar		niner 111 Per	nn Street	, Baltimore, M	D 21201			
Stat Registra	~	NAY 03	2010	and A.	par	w				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ Audrev Jane Leasure Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Western MD Regional Medical Center Cumberland 5. Social Security Number If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year 8. Date of Birth Funeral Min. (Month, Day, Year) 02/23/1914 1 □ M 2 🔽 F 214-05-8171 96 Director Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Cumberland 1 X Yes 2 ☐ No Allegany 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 701 Furnace Street 21502 USA items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces 0 ģ 1 Never Married 2 Married 1 Yes 2 72 hours after 21215-0036 1 ☐ Yes 2 🙀 No Specify: "natural", 3 V Widowed 4 Divorced Completed Year or Dates White traumatic event, the Modical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumastic. 12 Homemaker Home Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Alvin Walter Twigg Trixie Carder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary G. Leasure / Son 813 Windsor Road, Cumberland, Maryland 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔲 Burial 2 💢 Cremation 3 🗆 Removal from State cemetery, crematory or other place, Cumberland Crematory 04/26/2010 4 Donation 5 Other (Specify) Cumberland, MD 21. Signature of Funeral Service Lige 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examir anding physician and use as the burial-transit The law requires that the death certificate be executed that initiated events as a consequence of): resulting in death) Last Due to (or the attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗷 No P 5 Other (specify) Pregnant at time of death signed by the a 1 Yes 2 pg Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an page 2 s prior to completion of cause of death? has performed? Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: ည 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aff completed filled in by the ful 1 Tes 2 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, gearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 2 of person who completed cause of death (Item 23a) (Type, Print) n RA

Registrar DHMH 17 Rev 7/2009

State

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2010

32. Registrar's Signature

Jillow broo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ April Deborah Jean 13 1905 hrs/. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Hospital Center Cheverly Prince Georges 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1957 **Funeral** Months Days Hours Min. 217-72-0180 52 **Director** 19 Washington, D.C October Usual Residence of Decedent ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Maryland Landover 1 Yes 2 No Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 20785 United States 6715 Vermont Court 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2X Married þ Baltimore, Maryland 21215-0036 **Black** 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Customer Service Representative (unknown) 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ည Constance **Bryant** Petty Green Grayson permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic once. traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6715 Vermont Court; Landover, Maryland 20785 Andrew Lee, Jr. (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Waldorf, Maryland 4 Donation 5 Other (Specify) Heritage Memorial Cemetery Inature of Funeral Service 22. Name and Address of Facilities. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiac Arrhythmia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Right Mild Hemothorax Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Duri to (or as a nonsequence of): Cause (Disease or linjury that initiated events resulting in death) Last Coronary Artery Disease Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Physician/Medical Chronic Renal Failure Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Day Month Year 9 X Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Morbid Obesity Completed 1 Yes 2 No 3 Probably 4 X Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Diabetes has autopsy performed? death? certificate 2 🗌 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🗶 No ျ 1 X Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After X Natural 5 Pending 1 Yes 2 No Investigation
6 Could not be Accident filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours after within 24 hours To the Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a, Certifier (Check and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my know death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi completed cause of death (Item 23a) (Type Print) M.D.; 3001 Hospital Drive; Cheverly, Maryland 20785 Mohammad Nafficy Date filed (Month, Day, Year) 32. Registrar's Signature State APR 2 8 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 17. Lawlor Bernice 8:52 p Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 15300 Beaverbrook Court, #1J Silver Spring Mon toomery 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F Months Hours Month Day Ye April 21, ^{rear} 1927 **Director** 042-22-3525 82 Yrs Connecticut Usual Residence of Decedent or 28a-f shov notified at show 10a. State 10b. County within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Montgomery Silver Spring 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o edical Examiner must be Funeral 15300 Beaverbrook Court, #1J 20906 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ♣ No Black, White, etc þ 1 Never Married XX Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 🗷 No Specify. Specify 3 Divorced 4 Divorced Completed the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bacteriologist Government. e 1 and 2 should be filed wit of Health and Mental Hygie If item 27 is marked other in other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Oswald Aubertin Helen Morrisey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward W. Lawlor/Husband 15300 Beaverbrook Court, #LJ, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ₽ permit. Page 1 Department of Important: If it any injury or or 1 🗌 Burial 2 🛣 Cremation 3 🔲 Removal from State April 2010 Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Signature of Funeral Service Licenses 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death **Years** shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Parkinson's Disease disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Dementia 3 years Sequentially list conditions, if any, leading to immediate cause Enter I have him Cause (Disease or iinjury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transil that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year cate has been signed by the a page 2 should be detached 1 ☐ Yes ∠ □ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension, Osteoporosis, Infected Sacral Decubitus Ulcer 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Director; After this certificate has I performed? Yes 2 No 1 🗌 Yes 2 🗌 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 🖰 No 1 Tes Other: 욘 1 Inpatient 2 Inpatient 3 Inpa 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1x Natural 5 Pendina 1 Yes 2 No Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in by determined 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

within 2

only one) 29b. Signature and title of certific

31. Date filed (M

Robert Trimble, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

2. Registrar's Signature

10810 Connecticut Avenue, Kensington, MD 20895

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D69221

29d. Date signed (Month, Day, Year)

April 19, 2010

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Mai	-	•	icate of De			g. No.	0	4102
	Physicia	an	1. Decedent's Name (First, Middle, La		-2				2. Date of Death Month	Day Y	ear	3. Time of Death 1:15 a M
	/Medic	al	4a. Facility Name (If not institution, give	Yuliy Libr	nan	4h	. City, Town, or Loc	ation of Death	April	19, 201		1.13 a.w
)	Examin	er	Hebrew Home of Gr		inaton		•	kville				gomeruj
	Funeral Director		5. Social Security Number 6. S		(In yrs. last birt		Under 1 Year If U	Jnder 24 Hrs. ours Min.	8. Date of Birth (Month, Day, 1987)	Year)		ace (State or Foreign
	p		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location	on		02,2.,.		10	0d. Inside City Limits
	e Maryla a-f sho iffied at	ctor		jomery	,			ockville	e			1 TyYes 2 □ No
	th with th 23a or 28 ist be no	al Director	10e. Street and Number 5 Maxim La	ıne		1	0f. Zip Code	20852	10	g. Citizen of Wh	u.S	
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	/ Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give			Decedent of Hispar is, specify Cuban, M Yes 2 No St	nic Origin? (Spe lexican, Puerto pec <i>ify:</i>	ecify Yes or No- Rican, etc.)	14. Race - Black, Specify:	America White, 6	
	2 hours atural", cal Exa	ted by	3 ☐ Widowed 4 🗷 Divorced 15. Decedent's E	Year or Dates:	16a.	Decedent	's Usual Occupation)	1	6b. Kind of Busi	ness/Ind	White ustry
7	thin 7: ie. ian "n Medi	Completed	(Specify only highest gr. Elementary/Secondary (0-12)	College (1-4or 5+))		l of work done durin NOT use retired)		ing	~! •.		0
7	2 should be filed withi and Mental Hygiene. Is marked other thar aumatic event, the M	Co	17. Father's Name (First, Middle, Lasi	5+	Me	chani	cal Engir		e (First, Middle, M	Theatr		vesign
2	d be fi	o Be		sh Libman			10.	Wolfier 3 Name		a Mart		
7	should md Me mark	은	19a. Informant's Name/Relationship		19b.	. Mailing A	ddress (Street and i	Number or Rura			ate, Zip	Code)
MC	1 and 2. Health a sem 27 is other trau		Luba Tsaturova -	· Daughter	5	Maxi	im Lane, 1	Rockvil	le, Mary	land 201	352	
ב כ	ges 1 gof He of He or othe		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State			n (Name of ory or other place)			0c. Location - C	•	
	tment tant: tant:		4 ☐ Donation 5 ☐ Other (Speci	fy)	Judean		rial Grd					
þ	permit. Pages 1 Department of H Important: If ite any Injury or ot once.		21. Signature of Pineral Service Lice	Donne !	CFSP							Home, Inc. 3, MD 20904
	11-12-		23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications hat caused the	he death. Do r	not enter th	ne mode of dying, su	uch as cardiac	or respiratory arres	st,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		etatic		rostate		1ces			Onset and Death
'	/Medical Examiner		resulting in death)	Due to (or as a	consequence of	of):						
B)	- AG 	ē	Sequentially list conditions,	b. Due to for as a	consequence of	of):					-	
	uted d ansit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C								
Š	be exec ician an burial-tr	al Exa	resulting in death) Last	Due to (or as a	consequence of	of):						
00/00	ficate g phys is the	edical		_d				5.4				
.C. DO.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pt 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Pi ⊟Fetal déath		topic pregnancy her (specify)			23d. Date Mont		ry Day Year
Ĺ	s that ined b e deta	by Ph	Part II. Other significant conditions	contributing to death but	not resulting in	the under	tying cause given in	Part I.	23e. Did toba	acco use contrib	ute to th	e cause of death?
COLOS,	equire en sig ould b	ed b							1 ☐ Ye	s 2 □ No 3	☐ Prob	ably 4 Unknown
שמ	The law rute has be	Completed				_			24a. Was an autopsy perform 1∐ Yes 2	/ pri ned? de	ere auto or to cor ath?]Yes	psy findings available mpletion of cause of 2□ No
9	ctor, p	Be C	25. Was case referred to medical examiner?	¢.				. Place of Deatl	h (Check only one	/		
5	physic this or al dire	မ	1 ☐ Yes 2 No		t 2 ER/Ou	·			me 5 Resider			/)
5	ding F	ion:	27. Manner of Death 1 Manner of Death 5 ☐ Pending investigatio	28a. Date of Injury (Month, Day	Year) 286. I	Time of njury	28c. Injury at Work? M 1 ☐ Yes	2 □ No	28d. Describe how	w injury occurred	3	
	I or Atten after death Director:	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	e Dince of injun	y - At home, fa (Specify)				28f. Location (Str. City or Town,		or Rura	l Route Number,
	e Hospita 24 hours e Funeral	Medical C		hysician: To the best of miner: On the basis of e and manner state	examination an							
	To th within To th	Me	29b. Signature and title of certifier	*			29c. License nu	mber	29	d. Date signed	(Month,	Day, Year)
ì	3		rnina Har	.ll.			D006	487	1	4-19-3	105	0
			30. Name and address of person who	completed cause of dea	ath (Item 23a) (6 105	(Type, Prin	trass	Rd	ROCKI	Tille, m	0	2085 2
	Sta Registr		31. Date filed (Month, Day, Year)	82. Registrar	r's Signature	arke	trose					
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Registrar DHMH 17 Rev 7/2009

State

10+1

29b. Signature and title of certifi

31. Date filed (Month, Day, Year)

Barbara Supanich, MD

Supanich

Rsm

Registrar's Signature

Maryland 21215-0036

Baltimore,

Box 68760

Records,

Division of Vital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Barbara Supanich, MD 1500 Forest Glen Road, Silver Spring, MD 20910

D 0065485

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Apr 6, Physician/ 2010 10:30 pm Myrtle Agnes Lee Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 215 Wempe Drive Allegany Cumberland Social Security Number 9. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth Funera Hours 1 🗆 M 2 😾 F Month Day Xea MD Director 578-05-4190 96 Usual Residence of Decedent or 28a-f show and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director iral", or items 23a or 28a-f s Examiner must be notified 1 □ Xres 2 □ No MD Allegany Cumberland 10e. Street and Number 10g. Citizen of What Country? Funeral 215 Wempe Drive 21502 USA Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. 27 is marked other than "natural", or i traumatic event, the Medical Examin Completed by 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates white 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) dress buyer dept. store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William R. Durbin Delia (Flaherty) Durbin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Judith Carr 215 Wempe Drive Cumberland MD 21502 daughter injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it 1 🖪 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Hillcrest Memorial Park 4/9/2010 MDCumberland 21. Signature of Funeral Service Licensee 22. Namesond Address Purieral Home, PA Han 108 Virginia Avenue: Cumberland, MD 21502 23a. Pa. 1. Enter the disease, or complications to treat caused the feath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 000 has disease or condition Medica! resulting in death) Due to (or as a conseq erice of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) that the death certificate be executed Cause (Disease or iinjury that initiated events the burial-trans and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown Yes 2 No 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacço use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. Division of Vital the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2. No Other: ၉ 1 🗀 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death

1 Natural

2 Accident

3 Suicide 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street-and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 000 33 280 2010 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MLK Sunil Gupta, M.D. 625 Kent Avenue Cumberland MD 21502 32. Registrar's Signature State 13 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1:45 PM Light Eugene M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Allegany 8003 Hilltop Drive Cumberland Social Security Number 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth Hours Nov 4 . 1<u>923</u> **Director** 217-18-4434 86 ral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director MD Allegany Cumberland 1 □xYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 8003 Hilltop Drive USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 XWidowed 4 Divorced WW II white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Kelly Springfield Tire manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Myers G. Light Jeanette (Barrett) Light 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
w 1301 Kentucky Avenue Cumberland MD 21502 W. Gary Miller 1301 Kentucky Avenue son-in-law 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Sunset Memorial Park 4/15/2010 MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Ser 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death +hysician/ Medical resulting in death) Due to (or as consequence of): Examiner Sequentially list conditions Examiner Due to or as a consequence of if any leading to immedicause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and -tran Due to (or as a consequence of) attending physician of for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 9 Unknown 9 Unknown been signed by t should be detach Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a, Was an has autopsy death? certificate 1 🗌 Yes 2 🗆 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 I DOA After this (27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: Jo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certilie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7AMANMÎ WIIIOWBR year 5 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** MABEL MAY LOFLAND 29 2010 9:25 p APRIL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1115 Busic Church Rd. Marydel Queen Anne's If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jan 19 1931 9. Birthplace (State or Foreign Social Security Numbe 7. Age (In vrs. last birthday) Funeral 1 □ M 2 🛣 F Delaware 79 220-26-3534 Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 1 ☐Yes 2X No notified Director MD Queen Anne's Marydel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code a or death with 1115 Busic Church Rd. 23a U.S.A. 21649 Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian or items Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2√ If Yes, Give Year or Dates: 2**√** No 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No White Specify: þ 3 Widowed 4 Divorced "natural" Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home Ith and Mental Hygier
7 is marked other the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Lacey Clough 2 Matilda Lulu Tharpe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra of Health James Franklin Lofland (husband) 1115 Busic Church Rd. Marydel, MD. 21649 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Sudlersville, MD. Sudlersville Cemetery 5/7/10 f Funeral Service 22. Name and Address of Facility Galena Funeral Home of Stephen L. Schaech 21. Sign 1¶00510 118 West Cross St. Galena, MD. 21635 23a. Rant Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cruss on each line. Approximate Interval Between Onset and Death Immediate Cau e (Final disease or dition resulting in death) Julmonay **Physician** 4ears Mrong /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2 1 NO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 | Yes 2 | No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: d in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours the Funeral Dirr 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10

State Registrar

DHMH 17 Rev 1/2001

Chestertown, MD.

21620

516 Washington Ave.

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32. Rec

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Susan K. Ross, M.D.

MAY 05

			1 - For State Registrar	State of M	laryland /	Departme Certifica			nd Mental H	ygiene Reg. No.	2010	
	Physicia Medic		1. Decedent's Name (First, Middle, L. Dora	C.	Mi	.lburn-M	ortim	ore	2. Date of D		1 Dear	3. Time of Death
9	Examir		4a. Facility Name (if not institution, gir WM HS RMC			CU	y, Town, or I	RLA	ND	A	County of Dea	
	Funeral Director			Sex 7. Ag	ge (In yrs. last bir 93	Yrs. If Und Month:	er 1 Year Days	If Under 2	4 Hrs. 8. Date of E Min. (Month, L	Day, Year)	Co	nthplace (State or Foreign ountry) nnsylvania
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	10a. State 10b. County MD Alle 10e. Street and Number	gany	10c. City, Tow	Cumb	erland	i .		10a. Citi	zen of What C	10d. Inside City Limits 1 Yes 2 □ No ountry?
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	nd 2 shoul lealth and I m 27 is m		19a. Informant's Name/Relationship Bernard Milburn		2	06 Glea	son St		or Rural Route Numb , Cumberla			· '
Baltimore,	t. Page 1 a tment of H tant: If ite ijury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec		cemete		other place lem • P	ark 0	Date 4/30/2010	Be	dford,	PA
Bal	permit Depar Impor any in		21. Signature of Funeral Service/Nice	udanos		404	Decati	ır Stı	reet, Cumb	perla		Home, P.A. 21502
	Physician/ Medical		23a. Part 1. Ner the disea e, or or shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each lin	e. TEREI	ME			TATUS	arrest,		Approximate Interval Between Onset and Death DAYS
	Examiner	ner	Sequentially list conditions	bS	a consequence EPSIS a consequence							DAYS
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(nol		30. Name and address of person who RAV(AI) 31. Date filed (Month, Day, Year)	YER M.	, ,		lowbr	ook R	oad, Cumbe	erlan	d, MD	21502
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2 70 RS		30. Name and address of person who Robustiano J								e 302,				,	21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep	partment of Health and Nertificate of Death		2010	11.109	
			Registrar 1. Decedent's Name (First, Middle, Last)	Timeate of Beati	2. Date of Deat	leg. No.	3. Time of Death	
	Physicia		BETTY RUTH McCRAE		April	1 ^{Day} 20 ^{Year}	2:46 p M	
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	Inpraz_	4c. County of Dea		
	Examm	ler	5502 Karen Elaine Dr. #918	New Carrollton		Prince G		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,		8. Date of Birth	Birth 9. Birthplace (State or Foreign		
	Director		248-92-8199 1 M 2 TSF 65 Yrs.	Months Days Hours Min.	Aug. 6,	Year)	tinplace (State or Foreign suntry) SC	
	À		Usual Residence of Decedent					
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η the	a or be n	a D	10e. Street and Number	10f. Zip Code		10g. Citizen of What Co	ountry?	
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deat	r iten		11. Marital Status 12. Was Decedent Ever in U.S. 13 Armed Forces?	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit		
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yland ild be filed	Department of Health and Mental Hygiene. Important: If item 22a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	잍	Samuel Stuckey	Mabel B	risbon			
Mary 2 should	and N is ma suma		19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ling Address (Street and Number or Run	al Route Number,	City or Town, State, Zi	p Code)	
, ∃	n 27 n 27 er tra		Tarsha Britt - Daughter 1900	Oregon Ave. Lan	dover, M	D. 20785		
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Page	ment: Pant:			itan Crematory 4-2	21-2010	Alexandra	, VA.	
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2	1		30. Name and address of person who completed cause of death (Item 23a) (Types 5 7 1 2 5 2 2 2 3 4 2 4 2 4 2 4 2 4 2 4 2 4 2 4 2	Ewerolole Mi	20	737		
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	Registra		APR 2 2 2010 Centre D. Marie					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April April 12:57р м 2018 Rochie McQueen. Ir. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Olney Montgomery Montgomery General Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 **X** M 2 □ F Days Hours Months South Carolina **Director** 66 Yrs 248-68-2819 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Montgomeru Silver Spring Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 13217 Partridge Drive 20904 U.S.A. 12. Was Decedent Ever in US 965 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛛 No Specify: Specify. Completed 3 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Š+ Parole Officer U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ Allie Cox Rochie McQueen. Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13217 Partridge Drive, Silver Spring, MD 20904 Maria M. McQueen - Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Crownsville Veteran 05/03/2010 Crownsville, Maryland 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Hines-Rinaldi Funeral Home, HO # 1070 1800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Acute Muocardial Infarction Minutes disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Atherosclerotic Cardiovascular Disease Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Hospital or Attending Physician: The law requires that the death certificate be executed Status after death.

Funeral Director: After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hupertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Elevated Cholesterol 24a Was an performed' 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 X Yes 2 \(\subseteq \) No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 Inpatient 2 X ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one 29b, Signature and title 29c. License number 29d. Date signed (Month. Day, Year, 1)0050410 20+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18101 Prince Philip Drive, Olney, Maryland 20832 nac Month, Day, Year) 🚀. Registrar's Signat 2 1 2010 APR

Registrar

State Registrar

1

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

400

Raymond M. White, MD

30. Name an inddress of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

29c. License number

D43539

1500 Forest Glen Road, Silver Spring, MD 20910

29d. Date signed (Month, Day, Year)

April 18, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ELLINOR EATON Month 04 NOBLE. 13^{Pay} 2010 10:25 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death THE DIXON HOUSE EASTON TALBOT 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕱 F Months Days Hours Min 08YO37Y927 Director 221-30-2853 82 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MD TALBOT EASTON 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 108 NORTH HIGGINS STREET 21601 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🗶 No Black. White, etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give 3 Widowed 4 X Divorced Specify: WHITE Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 JOSEPH MULLIKIN EATON KATHRYN O'NEILL JARRELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STEPHEN V. NOBLE/SON PO BOX 96, 8 MOOSE RUN, GRANTHAM, NH 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State CHESAPEAKE CREMATION 04/16/2010 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) STEVENSVILLE, MD Signature of Funeral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL
200 S. HARRISON ST., EASTON, MD 2160 HOME, PA JOHN MERCERO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ OLON CANCER Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for אוואס אבי להייאי that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{No} \) Month Dav Pregnant at time of death 5 Other (specify) Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy filled in by the funeral director, page 2 2 No 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be (26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6X Other (Specifit), IVING 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred injury Natural 5 Pending 2 🗆 No Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one) 29b. Signature 29c. License number 29d. Date signed (Month. Dav. Year) D3988 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID H. SMITH 8221 TEAL DRIVE, SUITE 301, EASTON, MD 21601 31. Date filed (Month 32. Registrar's Signature State APR 16 2010 Registrar

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	To the Hospitel or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Me	29b. Signature and title of certifier				29c. Licens			29d. Date sign	ned (Month,	Day, Year)	
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	Sta		31. Date filed (Month Day Year) 20)10 Separation 100 Se	rar's Signat	1º A	wend						
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 | | | For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ April 16, ^{Da}2010 Year 11:20PM Pretko Medical 4a. Facility Name (if not institution, give street and number)
Glade Valley Rehab. Center Examiner 4b. City, Town, or Location of Death Walkersville 4c. County of Death Frederick Social Security Number 9. Birthplace (State or Foreign Permy Ivania 8. Date of Birth Selfocth, Pay, 1927 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral Days Hours Min. 1 🔀 M 2 🗆 F 217-22-9980 82 Director Yrs. Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Marvland Frederick Walkersville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21793 306 Eastfield Place USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. 1 Never Married 2 Married Completed by Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: should be filed within 72 hours aft and Mental Hygiene. is marked other than "natural", White WW II 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Vice President Finance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ Borkowski John Pretko Helen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a 306 Eastfield Place, Walkersville, MD 21793 Jean Pretko/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ott 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 4/21/2010 Frederick, MD Resthaven Mem. Gard Signature of Funeral Service Lig 22. Name and Address of Facility Stauffer Funeral Home, PA 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1621 Opossumtown Pike, Frederick, MD Onset and Death Physician/ Cerebra Vascylar disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examir attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be IE EEMALE 23c. If yes, outcome of pregnancy
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Box 68760

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Division of Vital

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Examine		4a. Facility Name <i>(if</i> Dove	f not institution House	, give street	and numb	per)		4b. C	-	r Location of D			4c. County of Death Carroll		
Funeral Director		5. Social Security N 219–38–52	Number	6. Sex 1 🖺 M	2 🗆 F	7. Age (In yrs. 69	last birthda Yrs	Month	der 1 Year	If Under 24		of Birth		g. Birthp	blace (State or Foreign try) 255ee
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executed an and irial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or influry that Initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):													
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months? □ No	1 4	Live B	ome of pregna irth 2 Fet ant at time of own	al death	3		су				ate of delive	ery Day Year
uires that the signed by all die detaction	<u></u>	Part II. Other signit	ficant condition	ons contribu	iting to dea	ath but not res	sulting in th	ne underlyir	ng cause gi	ven in Part I.	236				ne cause of death?
sician: The law rec s certificate has bee lirector, page 2 sho	Completed										24	a. Was an autopsy performe Yes 2	ed?	Were autop prior to condeath? 1 Yes	psy findings available mpletion of cause of
rsician: s certific director,	To Be	25. Was case referrence examiner? 1 Yes 2		Hospit	al:	npatient 2	EB/Outos	atient 3	Oth	er:	Check only on		ca 6 IXI Oth	er (Specify	Hospice
ending Physath.	Certificate: T	27. Manner of Deat 1 Natural 2 Accident	5 Pendir	ng gation	Ba. Date of		28b. Timi injur	e of	28c. Injur	y at	28d. Des		injury occurr		,
vital or Attu urs after de ral Directo		3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Run City or Town, State)													
he Hosp in 24 ho he Fune ipleted fi	Medical	(Check 2	1 ☑ Certifying 2 ☐ Medical E 3 ☐ Certifying	Examiner: O	n the basis	of examination	n and/or in	vestigation,	in my opinio	on, death occur	red at the time	, date and p	olace, and du	e to the cau	use(s) and manner stated
To t To t COM		29b. Signature and	1/	-f-	pr.	~			D6	778 (0	29d. Date signed (Month, Day, Year)			
6+1064		30. Name and addr	ress of person			of death (Iten	n 23a) (Typ iness	e, Print) Cent	er Dr	ive , I	Reister	stown	n, MD	21136	5
State Registra	7	31. Date filed (Mont	th, Day, Year)	2 0 20	32. Reg	gistrar's Signa	457	400	Med						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ APRIL 2010 9:00 PM THURSTON EUGENE POOLE, SR Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** Days Months Hours 1 X M 2 🗆 F 78 NOVEMBER 26, 1931 MARYLAND Director 214-28-4688 Usual Residence of Decedent 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at 1 Yes 2 X No QUEEN ANNE'S STEVENSVILLE MARYLAND ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b Funeral 328 VIRGINIA ROAD 21666 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE res, Give Year or Dates. 1949-1955 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) CHIEF OF 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) PRESIDENTIAL College (1-4 or 5+) Elementary/Seconday (0-12) AIRCRAFT QUALITY CONTROL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ JESSIE HOBSON BURNS HARVEY POOLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1844 NORTHBRIDGE LANE, ANNAPOLIS, MARYLAND 21401 JAMES H. POOLE/SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, CROWNSVILLE
VETERANS CEMETERY 1 XI Burial 2 Cremation 3 Removal from State APRIL 26 4 Donation 5 Other (Specify) CROWNSVILLE, MARYLAND 2010 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ ACUTE MYSLARDIAL INFARCTION DAY Medical resulting in death) Due to (or as a consequence of): Examiner CORDNARY ALTERY DIJEASE Sequentially list conditions, If any, leading to immedicause. Enter Underlying Cause (Disease or iinjury Due to for as a nonsequence of Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician if or use as the burial. Physician/Medical Division of Vital Records, P.O. Box 68760 E FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4 Pregnant : 9 Unknown Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by DIABETES HYPERLINDEMIA 2 No 1 Tyes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No DISEASE 24a. Was an autopsy performe 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ၉ 1 ☐ Inpatient 2 K ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No ë 1 Natural 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After a completed filled in by the funer. 5 Pending Certificat Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 | Medical Examiner: On the basis of examination areas in recognition in the process of examination areas in recognition are recognition are recognitional areas in recognition areas in recognition are recognition are recognition are recognitional areas in recognition are recognition are recognition are recognitional areas in recognition are recognition are recognitional areas in recognition are recognition are recognitional areas in recognition are recognitional areas 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 041339 04-20-2010 10+1 100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

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Amile 31, Date filed (Month, Day, Year) SALLITT

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2<u>010</u> Physician/ April JIMMIE L. PAFFORD 19 7:21 p^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 612 Holiday Drive Pocomoke City Worcester Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 3, 1931 9. Birthplace (State or Foreign Country) **Tennesee** 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 🕱 M 2 🗆 F **Director** 78 Yrs. 411-44-0820 Usual Residence of Deceden or 28a-f show notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Pocomoke City Worcester 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 612 Holiday Drive 21851 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Yes 2 No Yes, Give Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Year or Dates. Korean Specify: white 3 Nidowed 4 Divorced of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Electronics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည be f Arvin L. Pafford Louise Goodman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Helen Pafford (wife) 612 Holiday Dr., Pocomoke City, MD 21851 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 4/21/2010 Salisbury Crematory Salisbury, Maryland Signature of Fune Service Licen Holandad Funfarial Home, Professional Association 107 Vine St., Pocomoke City, MD 21851 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Part 1. Enter the disease, or complications that cause on each line.

shock, or heart failure. List only one cause on each line.

Adenocarcinoma of the Submandibular Gland Approximate Immediate Cause (Final 1 Priset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate Physician/Medical Examiner Due to (or as a consequence of, if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a Was an has autopsy performed? prior to completion of cause of death? 124 hours after death. • Funeral Director: After this certificate 2 X No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital 2 (XNO Other: 잍 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred X Natural 5 Pending injury Acciden
Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only or re and title of cer 29b. Sign 29d. Date signed (Month, Day, Year) 04-20-2010 D0002556 and address of person who completed cause of death (Item 23a) (Type, Print)

BA 6

DHMH 17 Rev 7/2009

State Registrar Pocomoke City, MD 21851

MD - 100 8th Street,

32. Registrar's Signature

Santiano,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 17, Day 2010 Year Physician/ Edward Joseph Pohutsky 5:46 рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Montgomery Bethesda 5. Social Security Number Sex 1 M 2 D F If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min. oct. 30, 579-18-5189 88 Director 1921 Pennsylvania Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🔼 No Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 9615 Carriage Road 20895 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces? Black, White, etc. Completed by 1 Never Married 2 X Married 1 Yes : Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: White 3 - Widowed 4 - Divorced WWII Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Underwriter Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Joseph Pohutsky Josephine Edith Kinsel other traumatic and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 siment of Health amut: If item 27 i Rita J. Pohutsky/Wife 9615 Carriage Road, Kensington, Maryland 20895 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven
Cemetery 20a. Method of Disposition April 22, 20c. Location - City or Town, State permit. Page 1 Department of Important: If It any injury or o 1 🖾 Burial 2 🗌 Cremation 3 🗆 Removal from State Silver Spring, Maryland 4 Donation 5 Other (Specify) 22 Prancissy Factollins Funeral Home Inc. 500 University Blvd. W., Silver Spring, 21. Signature of Funeral Service Licensee MD 20901 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Sersis disease or condition resulting in death) weeks Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Durity for as a nonsectionou offi nding physician and use as the burial-tran that initiated events that the death certificate be exec Due to (or as a consequence of) resulting in death) Last Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box (3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Yes 2 ☐ No 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown ģ is cernicate has been signed I director, page 2 should be det Part II. **Other** si**gnificant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Renal Failure, Metabolic Acidosis, Ischemic Cardiamyopathy Hospital or Attending Physician: The law requires 2 🖪 No 3 🗌 Probably 4 🗌 Unknown Completed Divis An of Vital Record 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 DiNo မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: **X**Natural work? 5 Pending rpleted filled in by the fu 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 horrs Medical retrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check within 2 To the 6 only one 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certil 29d. Date signed (Month, Day, Year) 29c. License number D60117 April 19, 2010

DHMH 17 Rev 7/2009

State Registrar 8600 Old Georgetown Road, Bethesda, MD 20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Eric J. Park, MD

31. Date filed (Month, Day, Year) APR 21 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ NAOMI E. PATSY Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Months Hours Min. PE<u>NNSYLVANIA</u> 198-20-0855 Director 82 Usual Residence of Decedent shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No **ALLEGANY** CUMBERLAND MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1429 CHURCH STREET 21502 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: WHITE If Yes, Give 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) CO-OWNER 11 MONUMENT SALES Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ MARSHALL STEELE JANE LOWERY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOSEPH F. LEE / SON 7959 MT. DAVIS ROAD, MEYERSDALE, PA 15552 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) YELLOW CREEK CEMETERY 04/15/2010 HOPEWELL, PA 21. Signature of Funeral Service Living 22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET, CUMBERLAND, 23a, Part 1. Enter the disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Coronal disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine r any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence oi) or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Winknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy completed filled in by the funeral director, page 2 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred work? 1 PNatural injury 5 Pending 2 \square No 2 Accident
3 Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 1 Certi g Physician: o the st of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medica xaminer: Athesis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse xaccurren: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) ٥ D36766 Name and address of pason who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

APR

MLK

Registrar's Signature

umberland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Margaret Catherine Payne Physician/ Mavonth Day 2010 1 10:15Р. м Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's 9715 52nd Avenue College Park If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth
Feb. 13, 19921 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 215-18-9127 1 □ M 2 🂢 F 89 Maryland Director Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No Maryland | Prince George's College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9715 52nd Avenue 20740 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🐧 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: If Yes, Give Specify. 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondayr(0-12) College (1-4 or 5+) Secretary Research Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည Walther Dohrman Charles Marie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other traus 1597 Homeland Drive,#3A Sykesville, Maryland 21784 Robert P. Payne -husband 20a. Method of Disposition
1 ☐ Burial 2 XCremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Metropolitan Crematory 5/3/2010 Alexandria, Virginia 4 Donation 5 Donation 5 Other (Specify) Signature of Funeral Service Liceny 22. Name and Address of Facility Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Ma Maryland 20705 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death WEEKS shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Ph_sician/ Colon Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence or): physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 X No
9 Unknown as been signed by the atte 2 should be detached for Month Day Year Pregnant at time of death g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy performed? After this certificate har death? 2 🕅 No 1 Yes å 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify, 1 🗌 Yes 2 🔀 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after death

To the Funeral Director: A

completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the only one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) May 3, 2010 D14686

State Registrar 31. Date filed (Month, Day, Year)

Francis Chucker, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

parke

2700 Calvert Street, N.W. Washington, DC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Andrea Mary Rung 6:44 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Washington County Hospital Center Hagerstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min (Month, Day, Year) Director 67 215-42-4605 04/02/1943 Maryland Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Boonsboro 1 🗆 Yes 2 🔀 No MD Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 9365 Childacrest Drive 21713 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 😾 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify: Specify: 3 Divorced and Mental Hygiene.

s marked other than "natura"
numatic event, the Medical E Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Margaret Brennan Ward W. Cramer Marv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21713 Childacrest Drive, Boonsboro, MD Walter L. Rung / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 and Department of F Important: If it any injury or o 1 🗌 Burial 2 💢 Cremation 3 🗌 Removal from State Cumberland Crematory 04/25/2010 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) Sidnature of Funeral Service Linea e 22. Name and Address of Facility Adams Family Funeral 404 Decatur Street, 21502 Cumberland, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Litter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 by the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Year Pregnant at time of death 9 Unknown detached 9 Unknown Division of Vital Records, P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy death? certificate | PM 2 No within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 410 ၉ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending Natural Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide City or Town, State) Medical 29a Certifier 1 Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License numbe

ORIGINAL

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completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatu

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30. Name and address of person who

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 16, Day 2010 Year Michael Joseph Ryan 2:35 рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carriage Hill of Bethesda Bethesda Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**₹** M 2 □ F Days Hours Virginia Director 214-14-1727 95 1914 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🖾 No Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 10422 Hebard Street USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates. 1943-45 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 4 Purchasing Manager Department of the Navy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Mary McKeon Michael Ryan ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rachel Ryan/Wife 10422 Hebard Street, Kensington, MD 20895 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of April 2010 20c. Location - City or Town, State cemetery, crematory or other place)

Mary of the Mills
Cemetery St. Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 27 Name and Address of Facilities Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Signature of Funeral Service Licenses Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PNEUMONA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within Fu hours after death.

To the Puneral Director: After this certificate has been signed by the attending physician and completed filled in by the Innerial investigates of the puneral precedulations of the Cause (Disease or imjur) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Other (specify) Month Day Year 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 2 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? Accident 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) sus, MA 4120110 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

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Registrar's Signat

MD

Rockville MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 18, Day 2010 Year Physician/ 351 P Rumizen Dorothy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 14401 Traville Garden Circle #306 Rockville Montgomery Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Days Min Hours 1 1977/1919 VashThgton, DC 90 577-14-4978 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State death with the Maryland Director 1 X Yes 2 ☐ No Rockville MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20850 United States 14401 Traville Garden Circle #306 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married within 72 hours after White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar Specify 3X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Procurment Officer US Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Rebecca Shuman Morris Greber 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9013 Holly Leaf Lane Bethesda MD 20817 <u>Joy Ammerman - daugh</u>ter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
King David Memorial
Gardens 1 X Burial 2 Cremation 3X Removal from State 04/21/2010 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Edward Sagel Funeral Direction Inc MO1153 Signature of Funeral S 1091 Rockville Pike Rockville MD 20852 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Multiple Myeloma 4 years Medical resulting in death) Examiner vears Senile Dementis Sequentially list conditions, if any, leading to immediate cause. Enter onderlying Cause (Disease or iinjury Due to (or as a consequence of): The law requires that the death certificate be executed Exami burial-transit year <u>Failure to Thrive</u> and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 1 Live Birth 2 Fetal death 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day 1 Yes 2 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Division of Vital Records, 1 Yes 2 X No 3 Probably 4 Unknown Completed Chronic Anemia page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 24 No has 1 ☐ Yes 2 X No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 1 X Yes 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 IDOA 5 Residence 6 Other (Specify) မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 3 Sulcide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 🙇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatu and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2 D27285 April 19, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

APR 21 2010

acked

Michael Weinstein MD 5550 Friendship Blvd Chevy Chase MD 20815

62. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		State of Maryland / Dep		-	_								
		_ FOr	Certificate of Death Reg. No. 2										
		Decedent's Name (First, Middle, Last)		2. Date of Dea Month	ath Day Year	3. Time of Death							
Physicia /Medic		DAISY GERTRUDE S	MITH	April	18, 2010	3:00 A™							
Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death Frederick								
		6601. Fish Hatchery Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Thurmont If Under 1 Year If Under 24 Hrs.	8. Date of Birt		thplace (State or Foreign							
Funeral Director		220–16–2280 1 M 2 F 86 Yrs.	Months Days Hours Min.	8. Date of Birt (Month, Da Feb • 25	, Year) 1924 Ma:	ryland							
pu ,		Usual Residence of Decedent				10d. Inside City Limits							
laryla shov	ō	10a. State 10b. County 10c. City, Town or L				1 □Yes 2 □No							
the N	Director	Maryland Frederick Thurmont 10e. Street and Number	10f. Zip Code		10g. Citizen of What Co								
h with	al Di	6601 Fish Hatchery Road	21788		U.S.A.								
ems a	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13.	. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No Rican, etc.)	- 14. Race - Am Black, Whit								
s afte	by Fi	1 Never Married 2 M Married 1 Yes 2 M No If Yes, Give 3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify:	White							
2 hour	ted	15 Decedent's Education 16a, Dec	edent's Usual Occupation		16b. Kind of Business								
thin 72 ie. an "n	Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of work DO NOT use retired)	king									
led wi lygien her th			memaker	o /First Middle	Own Home	e							
d be fi	To Be	17. Father's Name (First, Middle, Last) Keefer Cornelius Rice		Name (First, Middle, Maiden Surname) he Gertrude Linton									
should nd Me mark umarti	ĭ	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co											
and 2 salth a n 27 is er trai		Orville Smith / Husband 6601	Fish Hatchery Roa	ad, Thur	mont, MD 2	1788							
es 1 and He			ematory or other place)	Date	20c. Location - City or	Town, State							
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinant and De rofflind at once.		4□Donation 5□Other (Specify) Resthave	n Mem. Gardens 4/2	21/10	Frederick,	Maryland							
permi Depar Impor any ir		R	22. Name and Address of Facility ROBERT E. DAILEY & p.1.5 EAST MAIN STREI	SON FUN	ERAL HOMES	P.A. 1788							
		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.				Approximate Interval Between							
Physician		Immediate Cause (Final disease or condition	U CANCER			Onset and Death							
/Medical Examiner		resulting in death) Due to (or as a consequence of):											
	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):											
cuted nd ransit	Examiner	Cause (Disease or injury that initiated events c											
oe exe cian ar urial-t		resulting in death) Last Due to (or as a consequence of):											
cate b	dical	d											
certifi nding	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of de	23d. Date of delivery							
death e atte	Physician/Medi	in the nact 12 months?	B ☐ Ectopic pregnancy □ Other (specify)		Month	Day Year							
at the	Phys	9 Unknown	and discourse since in Dodd	220 Did t	obacco use contribute	to the cause of death?							
ires th signed	þ	Part II. Other significant conditions contributing to death but not resulting in the AORTIC STENOIS (REPAILED)	ungeriying cause given in Part I.	1 🗆 '	_, _	Probably 4 Unknown							
requ been should	Completed	ADEILE STENDAS (KETAINES)		24a. Was		autopsy findings available							
he lav e has	dmc			auto perfo	psy prior to prmed? prior to death?	completion of cause of							
an: T rtificat tor, pa	Be Co	25. Was case referred to medical	26. Place of Dea	1 □Yes		s 2 No							
hysici his ce I direc		examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati	ent 3 DOA Other: 4 Nursing H	lome 5 🔀 Resi	dence 6 □Other (Sp	ecify)							
After t	on:	27. Manner of Death 1 ☑ Matural 5 ☐ Pending 28a. Date of Injury (Month, Day, Year) 28b. Time Injury	Work?	28d. Describe	how injury occurred								
Attenc death ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be determined			Street and Number or F	Rural Route Number,							
al or A s after Il Dire	Certification: To	4 Homicide determined building, etc. (Specify)		City or To	wn, State)								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.											
o the	Mec	29b. Signature and title of certifier	29c, License number		29d. Date signed (Mor	nth, Day, Year)							
		M mo	D32171		4/19/	١٥							
		30. Name and address of person who completed cause of death (Item 23a) (Type											
3		RICLIARD GOUGH PO BOX 32 31. Date filed (Month, Day, Year) 32. Registrar's Signature		0 217	43								
Sta Registr		APR 2 0 2010 Deneur A.	gales										

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Pr 21. 2010 Physician/ Scarpelli 10:00 pm James Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 108 Virginia Avenue Cumberland Allegany If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign Country) MD 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 1 ★ M 2 □ F Months Hours Min. (Menth Day Xear) 1914 **Director** 214-05-4312 96 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 □xYes 2 □ No MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 108 Virginia Avenue 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Y Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. Completed 3 Widowed 4 Divorced Year or Dates WW II white 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry grade completed) (Specify only highest and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) funeral home owner permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Nicholas J. Scarpelli 19a. Informant's Name/Relationship (Type, Print) Rosa (Blasiola) Scarpelli 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nicholas J. Scarpelli 820 Buckingham Road Cumberland MD 21502 son injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/26/2010 St. Marv's Cemeterv MD Cumberland 21. Signature of Funeral Service Licens 22. Nam Sod Addres Pureral Home, PA any 108 Virginia Avenue: Cumberland, MD 21502 Part 1. Enter the disease, or complication of that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CORONARY

Due to (or as a consequence of) disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Errier University Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the bunal-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FFMA! F: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 1 🗆 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 ☐ Yes 2 ☐ No 2 1 No Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at injury 1 Natural 5 \square Pending work? 2 No 2 Accident
3 Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Prantiemen To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nes 200 Glenn St. Suite 200 Cumberland MD 21502 Robustiano Barrera MD28 2010 32. Registrar's Signature State Barks Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Box 68760

P.O. I

Division of Vital

14128

		1 - For State Registrar	State 5	Cer	tificate of D	eath		Reg. No.						
Physic	cian/	Decedent's Name (First, Middle, Last Shirley	Jeann	atta	Shri	wan	2. Date of Dea	ath 1Day	Year	3. Time of Death 2235 M				
Med Exam	dical	4a. Facility Name (if not institution, give s		ecce	4b. City, Town, or	-		4c. Coun	ty of Death					
		Western MD Region				erland				egany				
Funer Directo		5. Social Security Number 6. Se 218-48-8863	7. Age (<i>ln yrs. l</i> as	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da)	y, Year)	Cour	place (State or Foreign htry) nsylvania				
and show 1 at	ō	101 0 1	10c. City,	Town or Lo	cation					10d. Inside City Limits				
Maryla 28a-f otified	irect	MD Alle	gany		Cumberlar	nd				1 🗆 Yes 2 🔀 No				
with the s 23a or s	Funeral Director	10e. Street and Number 12815 Woodward	d Drive, NE		10f. Zip Code	21502		109. Citizen of USA	i What Cou	ntry?				
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	ed by Fur	1 Never Married 2 🕅 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 🙀 No		ecify Yes or No- Rican, etc.)	14. Ra Bla Specif	ace - Americ ack, White, fy: W	The state of the s				
Baltimore, Maryland 21215-0036 bernit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", on you or other traumatic event, the Medical Exam	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Seconday (0-12)		(Give . life. D	dent's Usual Occupa kind of work done do O NOT use retired)	tion uring most of work	ing	16b. Kind of		ndustry				
d 2- led wit Hygie other i	Be	12 17. Father's Name (First, Middle, Last)		•	Clerk	18. Mother's Nam	e (First, Middle,	U.S.P Maiden Surnar						
ylan id be fi Mental arked	우	John	Yates			Cather	ine	Almed	a	Wilson				
, Mar, d 2 shoul salth and I n 27 is m		19a. Informant's Name/Relationship (Ty, Vernon D. Shrive		19b. Mailir 1 28	ng Address (Street a 15 Woodwa	nd Number or Run rd Drive	al Route Numbe , NE , Ci	r, City or Town, umberla	State, Zip nd, M	Code) ID 21502				
more age 1 an ent of He nt: If iten		20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗔 4 🗋 Donation 5 🗆 Other (Specify	Removal from State cer	metery, crer	osition <i>(Name of</i> matory or other place lemorial P	9)	Date	20c. Location	•	·				
Balti permit. P Departm Importa any inju	ouce	21. Sibrature of Funeral Service Ligense		22	2. Name and Addres	s of Facility Ada	ams Fam:	ily Fun	eral	Home, P.A. 1502				
- Livery		shock, or heart failure. List only or	a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nediate Cause (Final ease or condition ulting in death) A CALL STATE FAILURE Due to (or as a consequence of):											
Priysiciai Medic Examine	al	disease or condition resulting in death)	a. MULTISYSTE Due to (or as a conseque	nce of):	7+1LJR				\dashv	Onset and Death SHOURS 8 VEANS				
	ш.	Sequentially list conditions, if any, isauming to immediate cause. Enter Underlying	b. ABDOMINAL DINTOGUESSOUSCON	HON	TIC AT	204751	n			0 7 27715				
8760 Ifficate be executed og physician and as the burial-transit	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a conseque	nce of):		_								
8760 ifficate be en open physicial as the buri	Medical		d											
Box 68 death certific the attending ned for use as	Physician/Me	TIF FCIVIALE.	23c. If yes, outcome of pregnand 1 Live Birth 2 Fetal 4 Pregnant at time of de	death 3 [☐ Ectopic pregnanc	ý			Date of delivitionth	very Day Year				
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death. Is after death. In prince or After this certificate has been signed by a prince of in by the funeral director, page 2 should be detact	d by Ph	Part II. Other significant conditions co	ntributing to death but not resul	iting in the u	underlying cause giv	en in Part I. S EAS E			_	the cause of death?				
cord; law requi as been 2 should	Completed by	STROKE					24a. Was		o. Were auto prior to co death?	opsy findings available ompletion of cause of				
Tital Reco sician: The law r certificate has b irector, page 2 sl		ATRIAL FIBRI 25. Was case referred to medical	LLATION		26 DIs	ice of Death (Chec	1 Yes	2 No	1 🗌 Yes	2 🗆 No				
Vita hysicia nis certi I directo	To Be	evaminer?	lospital:	R/Outpatie	Othe	r·	ome 5 🗆 Resid	dence 6 🗆 Ot	ther (Specif	(y)				
on of adding Phath. r: After this e funeral	Certificate: 7	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	28b. Time of injury	work'	at ? Yes 2 🗆 No	28d. Describe h	now injury occu	rred					
Division all or Atters after deal or Director or in by the		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, str	reet, factory, office		28f. Location (S City or Tox		ber or Rura	al Route Number,				
To the Hospital or Attending Phys within 24 hours after death. Lao the Funeral Director: After this completed filled in by the funeral di	Medical	29a. Certifier (Check 2 Medical Examinonly one) 3 Certifying Nurs	ician: To the best of my knowled ner: On the basis of examination are e Practioner: To the best of my l	and/or inves	stigation, in my opinio	n, death occurred a	t the time, date a	and place, and d	due to the ca	ause(s) and manner stated.				
Co		29b. Signature and title of certifier	School		29c. License	number 17 45	(29d. Date sign	ed (Month,					
3		30. Name and address of person who c		23a) (Type, I	Print)					1 MD 01700				
	tota	Philip Schroed	ler, M.D., 125		llowbrook	: Road, S	uite 58	U, Cumb	erlar	nd, MD 21502				
Regis	state strar	31. Date filed (Month, Par Year) 9 2	010		backet									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Physician 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** The Johns Hopkins Hospital **Baltimore City** 8. Date of Birth (Month, Day, Year) 12/5/1957 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 M 2 J none 52 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 28a-f show 1 Yes 2 No Director Virginia Fairfax Vienna 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code U.A.E. ö United Arab Emirates items 23a 1721 Gosnell Rd. Apt#104 22182 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼ No If Yes, Give 14. Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 21215-0036 ö 1 ☐ Yes 2X No Arab Specify: \$ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education the Medical (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Be is marked of Salem Abushibs Aliyah Abushibs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) husband Health a 600 Wolf St. Baltimore, Md. 21287 Juma Khalifa Abushibs/ other t Department of Heal Important: If item 2 any injury or other once, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4/22/10 Abu Dhabi, UAE Family Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Universal Mortuary 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the dischse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 411 Kennedy St. Washington, DC 20011 Approximate Interval Between Onset and Death Immediate Cause (Final left Physician disease or condition resulting in death) /Medical **Examiner** troperitoneal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine nysician and the burial-transit The law requires that the death certificate be executed CEPTIFICATION APPROVED BY WEDICAL EXAMINER Due to (or as a consequence of) resulting in death) Last Box 68760. Physician/Medical 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3

Ectopic pregnancy Live birth Month Day in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) 9 Unknown Unknowr 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 Yes Division of Vital 26. Place of Death (Check only one) or Attending Physician: 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🗌 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ρ 28a. Date of Injury
(Month, Day Year)
April 19, 2010 27. Manner of Death 28b. Time of 28d, Describe how injury occurred Certification: 5 Pending investigation surgical complication 1 Natural Μ 1700 1 ☐ Yes 2 X No death. 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 600 North Wolfe Street Baltimore MO 4 - Homicide To the Hospital of within 24 hours at To the Funeral D **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) yletely and manner stated.

State

APR 21 Ragistrar

Vand

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Paul



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

April 19, 2010

29c. License number

RES-000

	Physici /Medic Examir
	Funeral Director
Baltimore, Maryland 21215-0036	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heatth and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23a or 28s-f show eny injury or other treumatic event, the Medical Expriner could be notified at once.
	Physician /Medical Examiner

1 - For State Registrar

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Yo the Funeral Director: After this certificate has been signed by the attending physician and

		Decedent's Name (First, Middle, Last)	·						2. Date of De	ath		3. Time of Death
sicia		Fern J. Snyder							April	19, ^{Da}	^y 2010 ^{Year}	12:20 pM
edic: mine		4a. Facility Name (II not institution, give street and number 3160 Gracefield Road, ET			,		Location o			40	County of Deat	George's
ral			ge (In yrs. las		If Under		If Under Hours	24 Hrs. Min.	8. Date of Birl _(Month, Da	th y, Year,	9. Birt	hplace (State or Foreign
tor		213-46-9040 1□ M 2☒F Usuat Residence of Decedent	95	Yrs.					Dec. 1	6,	1914 Ok	lahoma
4	Ì	10a. State 10b. County	10c. City,	Town or Lo	cation							10d. tnside City Limits
	ctor	Maryland P.G.	Silve	r Spr	ing							1 Tyes 2 No
	ai Director	10e. Street and Number 3160 Gracefield Road, ET	2126		10f. Zip (Code	2090	4		_	itizen of What Co SA	ountry?
	Funerai	11. Marital Status 12. Was Deceden Armed Forces	?	13.	Was Decede f Yes, speci	ent of H	ispanic Ori n, Mexicar	igin? (Sp	ecify Yes or No Rican, etc.)	*	14. Race - Ame Black, Whit	
	ρ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 2 ti Yes, Give Year or Dates			1□Yes 2	No No	Specify:				Specify: Whi	te
8	etec	15. Decedent's Education (Specify only highest grade completed)		16a. Deced	dent's Usual kind of worl DO NOT use	Cocupa k done d	ation during mos	t of work	ing	16b. h	Kind of Business	/Industry
	Completed	Elementary/Secondary (0-12) College (1-40)	5+)		memak						Own Hon	ne
	To Be (17. Father's Name (<i>First, Middle, Last)</i> Galen Jones							e (First, Middle, 1 Wertm		n Sumame)	
9		19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address	(Street	and Numbe	er or Run	al Route Numb	er, City	or Town, State,	Zip Code)
		Roger Eugene Snyder/son					Cour				e, MD 20	
ino io Am		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stat 4 ☐ Donation 5 ☐ Other (Specify)	_ сел	netery, crei	nsition (Nam matory or ot .itan	her plac		Αp	ril 20 2010		ocation - City or exandria	
once.	Ì	21. Signature of Funeral Service Licensee		Ť	ranti	LAddje	ss of all	lins	Funera	1 H	ome Inc.	
ä		Jans 9 Josep									ver Spri	ng, MD 20901
		23a. Part1. Peter the disease, or complications that cause shock, of heart failure. List only one cause on each	ed the death. line.	Do not ent	er the mode	of dyin	g, such as	cardiac	or respiratory a	rrest,		Approximate tnterval Between Onset and Death
an		resulting in death)	ed Dem									
cal ner		Due to (or a	is a conseque	nce of):								
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90	an/Medicai	d.										
8	Med	IF FEMALE:	57 . 662 5							- 1		
<u>. </u>	lan/	23b. Was decedent pregnant in the pact 12 months?	2 Fetat d	leath 3[,				23d. Date of de Month	livery Day Year
	Physici	1 ☐ Yes 21820Mgo 4☐ Pregnant 9 ☐ Unknown 9☐ Unknown	at time of dea	un se	Other (spe	эспу)						
900	by Ph	Part II. Other significant conditions contributing to death	but not result	ing in the u	nderlying ca	ause giv	en in Part	l.	23e. Did (tobacco	use contribute t	o the cause of death?
	d be								1 🗆	Yes 2	2 ∏ No 3 □ P	robably 4 Unknown
2	piet								24a. Was		24b. Were a	utopsy findings available completion of cause of
page	Completed								perfo	ormed?	death? lo 1 ☐ Yes	s 2 No
jo j	Be (25. Was case referred to medicat examiner?						e of Deat	th (Check only	оле)		
	2	1 ☐ Yes 2 № No Hospitat: 1 ☐ Inpa		P/Outpatie			4 🗆 14	ursing Ho			6 □Other (Spe	ecify)
Jana I	tion:	27. Manner of Death 1 Natural 5 □ Pending (Month, £	gury Day Year)	8b. Time o Injury	M 2	8c. Injur Wor	yat k? Yes 2.⊑	No	28d. Describe	now int	ury occurred	
o) rue	fica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of the	tnjury - At hom	ne, farm, st	reet, factory							lural Route Number,
	Certificati	4 ☐ Homicide determined building,	etc. (Specify)						City or To	wn, Sta	te)	
compielely illiad In by the luneral director, page z snouto be detached to	ledical (29a. Certifier (Check only one) Certifying Physician: To the besigned and manner	of examination									
duoo	Me	29b. Signature and titte of certifier	ma	ng M		. Licens	e number	D595	24		ate signed (Mon April 19	
		30 Name and address of person who completed cause o	f death (Item 2	23a) (Type.	Print)	oad,	, Sil	ver	Spring,	MD	20904	
Sta	te		strar's Signatu	ire								
gistr		APR 2 1 2010 Sente	w B.	Span	Kal							

Registrar

		Ple	ase Type or Pri					-	•	ible.		
		For State Registrar		aryianu 	•	tificate of L		1	ene g. No. 20	10	14/29	
Physicia Medi		Decedent's Name (First, Midd. Mary Ann	sull:	ivan				2. Date of Death Month April 1	oril 17, 2010 Year 3:4			
Exami		4a. Facility Name (if not institution Dove House-Carro				4b. City, Town, o Westmi	r Location of Death Inster		4c. County Carr			
Funeral Director		5. Social Security Number 578-50-2521	6. Sex 7. Ag 1 M 2 X F	e (In yrs. last 71	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Aug 18,	^{ear} 1938	9. Birthp Coun	place (State or Foreign try) D.C.	
uyland a-f show ied at	Director	Usual Residence of Decedent 10a. State 10b. County Manager 1 and		10c. City, T						1	0d. Inside City Limits 1 ☐ Yes 2 ♣ No	
ith the Ma 23a or 28s st be notif	ral Dire	Maryland 10e. Street and Number 7 Napa Valle	Montgomery y Road		Gait	10f. Zip Code 2087	78	10	10g. Citizen of What Country?			
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Funeral	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Morroce	151/		1	Vas Decedent of H f Yes, specify Cuba ☐ Yes 2 🙀 No	ispanic Origin? (Sp nn, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White			
n 72 hour e. ian "natui Medical	Completed by		nt's Education est grade completed) College (1-4 or 5	17	(Give I life. Di	O NOT use retired)	ation during most of work	ing	6b. Kind of Bu		_	
filed withi al Hygiene d other th event, the	Be	12 17. Father's Name (First, Middle,	Last)		Se	cretary	Federal Government 18. Mother's Name (First, Middle, Maiden Surname) Helen Ilq					
should be h and Ment: 7 is marked traumatic e	<u>ا</u>	Andrew Anders 19a. Informant's Name/Relations Karon P. Rillov	hip (Type, Print)				and Number or Run	al Route Number, C			*	
age 1 and 2 ent of Healt nt: If item 2 y or other 1		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip C										
Departm Departm Importal any injur		21. Signature of Funeral Service	Funeral	Home I	nc.	ing, MD 20						
Trysician/ Medical Examiner	l.	23a. Part 1. Enter the disease, of shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	a. Due to (or as	a consequen	Nos A	er the mode of dyin	g, such as cardiac	y dioc			Approximate Interval Between Onset and Death	
g physician and as the burial-transit	Medical Examiner	that initiated events resulting in death) Last	c	a consequen	ice of):							
the attending physic ched for use as the bi	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal de	eath 3 [th 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)				23d. Date of delivery Month Day Year		
been signed by the should be detached	ed by PI	Part II. Other significant conditi	ons contributing to death b	ut not resulti	ing in the u	nderlying cause giv	ven in Part I.				pably 4 Unknow	
certificate has been irector, page 2 sho	omplet							24a. Was an autopsy performe	d? p	Vere autor rior to colleath?	osy findings available mpletion of cause of	
is certific director,	Be	25. Was case referred to medical examiner? 1 Yes 2	Hospital:			Oth	ace of Death (Chec				*	
or Attending First ifter death. Sirector: After this in by the funeral d	Certificate: To	27. Manner o eath 1 _ tural 5 ☐ Pendi	28a. Date of inju (Month, Day gation not be	y, Year) ury - At home	3b. Time of injury	28c. Injury work M 1	4 ≥ Nursing Ho at	28d. Describe how 28f. Location (Street City or Town, S	injury occurre	d		
Hours :4 hours :7 Funeral I	Medical	(Check 2 Medical	Physician: To the best of Examiner: On the basis of e	xamination ar	nd/or invest	igation, in my opinic	on, death occurred a	t the time, date and p	place, and due	to the cau	use(s) and manner state	
Vithin 2 To the Comple	~	29b. Signature and title of certifie		/	-3-1	29c. License		290	. Date signed	(Month, L	Day, Year)	
		30. Name and address of person		eath (Item 23	Ba) (Type, P	rint) 826 Washi		ed wa	tmin	ster	ml	
Sta	te	31. Date filed (Month, Day, Year)		ar's Signature	la a	v.1	0					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death) Menth Physician/ 122 Charlotte F. Snyder Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Western Maryland Regional Medical Center Cumberland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 K Months Days Hours Min. (Month, Day, Year) October 31, 1909 Maryland Director 215-20-5443 100 Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10a. State within 72 hours after death with the Maryland 10c. City, Town or Location Examiner must be notified at Director 1 🌠 Yes 2 □ No Frostburg Allegany Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 55 Linden Street 23a Funeral U.S.A. 21532-13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black White etc. 5 þ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates. Specify: "natural", Completed 3 ₩ Widowed 4 □ Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Homemaker UNKNOWN ige 1 and 2 should be filed wit nt of Health and Mental Hygie t: If item 27 is marked other or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Rachel Folk Benjamin C. Filer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shu Department of Health an Important: If item 27 is any injury or other trau 21532-Frostburg Maryland 217 East Street Norm Snyder 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c, Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Frostburg April 17, 2010 Frostburg Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Bart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Betweer Onset and Death Immediate Cause (Final Physician/ DRONAR disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any coing time fate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence of the attending physician and hed for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregrant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) signed by the at Id be detached for 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 🗹 No Other:

the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

24 hours and recomme Euneral Director: After completed filled in by within 2 P 3

State Registrar 1 Yes

27. Manner of Death

Natural

Accident

4 Homicide

only one)

31. Date filed (Month, Day, Year)

Signature

29a. Certifier (Check

Suicide

5 Pending

and title of certifier

Investigation

determined

6 Could not be

ည

Certificate:

Medical

200 Clent

1 Inpatient 2 ER/Outpatient 3 I DOA

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

injury

28c. Injury at

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

work? 1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c, License number

28a. Date of injury (Month, Day, Year)

32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

4 Nursing Home 5 Residence 6 Other (Specify)

City or Town, State)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year)

				Please	State of M			idelible in artment of I		-		Legible.		
		•	For State Registrar			ia. y ia.		tificate of			Reg. No.	2010	4131	
	Physicia Medic		1. Decedent's Name (First, Dale) Edward		Smit	th		2. Date of Domestin Month April	Day	Year	3. Time of Death 10:30 A ^M	
and a	Examin		4a. Facility Name (if not ins	_					r Location of Dea			County of Death		
	Funeral		518 Holla 5. Social Security Number	nd Str		ge (In vrs. la	ast birthday)	Cur If Under 1 Year	nberland Tif Under 24 Hi	s. 8. Date of Bi	rth	Allegany 9. Birthplace (State or Foreign		
	Director		212-54-8151 Usual Residence of Deced	1 5	X м 2 □ ғ	60	Yrs.	Months Days	Hours Mir		ay, Year) /1950	Mar	yland	
	faryland Ba-f shov tifled at	ector	10a. State 10b. (County Allega	any	10c. City	y, Town or Loc	cation Cumberlar	ıd				10d. Inside City Limits 1 X Yes 2 □ No	
	with the N 23a or 28 st be not	Funeral Director	10e. Street and Number 518 Holla	nd Str	eet			10f. Zip Code	21502		10g. Citiz	en of What Cou	ntry?	
	death vitems	Fune	11. Marital Status		12. Was Decedent Armed Forces'			Vas Decedent of H Yes, specify Cuba	Hispanic Origin? (Specify Yes or No	1	4. Race - Americ		
980	rs after c ral", or Examin	Completed by	1 Never Married 2		1 Yes 2 If Yes, Give Year or Dates.			Yes 2 X No		no nican, etc.)	s	Black, White, pecify: Whi		
15-0	72 hou "natu edical	plet	15. E (Specify on	ecedent's Ed ly highest grad	lucation de completed)		(Give I	lent's Usual Occup kind of work done	during most of w	orking	16b. Kin	d of Business In		
212	within giene.	Con	Elementary/Seconday ((0-12)	College (1-4 or	5+)		o <i>NoT use retired)</i> aborer			Fr	eight		
land	be filed view that Hygerked other tices of the tices of t	To Be	17. Father's Name (First, M Richard	, ,	Chemnitz		Smith		18. Mother's N Dorot	ame (First, Middle hy M	, Maiden St ay	urname) Cozad		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental lytigene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Re Jeanie M. S				19b. Mailir 5 1 8 I	g Address (Street Holland	and Number or F Street,	Rural Route Numb Cumberla	er, City or T	own, State, Zip (laryland	^{Code)} 2 1 502	
nore,	age 1 and ant of Hea nt: If item y or othe		20a. Method of Disposition 1 🔀 Burial 2 🗆 Crei 4 🗋 Donation 5 🗀 0	mation 3		C	emetery, cren	sition (Name of natory or other plan Mem • Gal	ce)	Date /21/2010		ation - City or To		
Baltir	permit. P Departme Importar any injur once.		21. Signature of Funeral \$			110.	22	. Name and Addre	ss of Facility A	dams Fam	ily F	uneral	Home, P.A.	
		Н	23a. Part 1. Enter the dise	ase, or comp	lications that cause	ed the deati		04 Decation of the mode of dying				1, 1410 2	Approximate	
	Physician/ Medical		shock, or heart failure Immediate Cause (Final disease or condition resulting in death)	e. List only on	NON Sm	IIA.	CEII	CARCIN	IONA O	f Lux	16		Interval Between Onset and Death	
	Examiner	16		s. 1	Due to (or as								M/12 2008	
	uted nd ansit	amine	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or linjury that initiated events	te 🐇	Due to (or as	s a consequ	uence of):							
9	e be executed ysician and e burial-transit	ical E	resulting in death) Last	L	Due to (or as	s a consequ	uence of):							
928	tificate ing phy e as the	Med	IF FEMALE:	(See 1)										
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medical Examiner	23b. Was decedent pregna in the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ii it	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta at time of c	aldeath 3 🗆	Ectopic pregnand Other (specify)	су		23	3d. Date of deliv Month	ery Day Year	
, P.O.	s that the igned by be detacl	by Ph	Part II. Other significant o	onditions co	ntributing to death	but not res	ulting in the u	nderlying cause gi	ven in Part I.				he cause of death?	
ords	v require been si should	oleted								24a. Was	an	24b. Were auto	bably 4 Unknown psy findings available	
Rec	: The lav	Comp									psy ormed? 2 🗹 No	prior to co death? 1 Yes	empletion of cause of	
ital	sician certifi irector	To Be	25. Was case referred to m examiner? 1 ☐ Yes 2 ☑ No		lospital:		FD (0	Oth	lace of Death (Ch			7		
of \	ling Phy 1. After this uneral d	ate: T	27. Manner of Death 1 ☑ Natural 5 □	Pending	28a. Date of inj	ury	28b. Time of injury	28c. Injur work	y at </th <th>Home 5 X Res 28d. Describe</th> <th></th> <th></th> <th>/)</th>	Home 5 X Res 28d. Describe			/)	
Division of Vital Records,	or Attend fter death irector: A in by the f	Medical Certificate:	3 Suicide 6 🗆	Investigation Could not be determined	28e. Place of In	jury - At ho tc. <i>(Specify</i>		M 1 Li	Yes 2 No	28f. Location (Number or Rurai	I Route Number,	
Ö	ospital of hours at uneral D	lical C	29a. Certifier 1 💢 Ce	rtifying Physi	ician: To the best o	of my knowl	edge, death o	ccured at the time	e, date and place,			manner as state	ed. use(s) and manner stated.	
	o the Harin 24 or the Fu		(Check 2 Me only one) 3 Ce 29b. Signature and title of	nitying Nurse	e Practioner: To the	e best of my	h and/or invest / knowledge, d	leath occurred at the	e time, date and p	at the time, date place, and due to the	ne cause(s) a	and due to the ca and manner as st signed (Month, a	ated.	
	5		•	1				D002	3371			pril 19		
	nds		30. Name and address of Qamar U	Zamar	n, M.D.,	1250	2 Will	rint) owbrook	Rd, Ste	440, Cui	mberla	and, MD	21502	
	Stat Registra		31. Date filed (Month, Day, APR 19 2	Year)	32. Regist	rar's Signat	and I							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Shreve, Sr. William James Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Cumberland Western MD Regional Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) Funeral Days Hours (Month, Day, Year) 1 ፟፟∭ M 2 □ F 76 Director 236-48-3250 07/22/1933 Maryland Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🌠 Yes 2 🗆 No Cumberland Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 212 Seymour Street 21502 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Tractor Trailer Driver Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္ပ Shreve, Sr. Hazel Viola Arlie Berry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randy L. Shreve/ Son 1700 Garden View Drive, Cumberland, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. 1 ☐ Burial 2 🏹 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory 04/15/2010 Cumberland, MD 22. Name and Address of Facility Adams Family Funeral Home, of Funeral Service Licen 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on terval Between Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been accounted to the Funeral Director. the attending physician and hed for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death After this certificate has been signed by the a funeral director, page 2 should be detached 9 Unknown Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 110 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA No မှ 1 Tyes 27. Manner of Death Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work' 5 Pending safter death.

Director: Aff
d in by the fur 1 Yes 2 No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined completed filled in by 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature

erson who completed cause of death (Item 23a) (Type, Print)

Bever1y

Calkins, M.D., 600 Memorial Avenue, Cumberland, MD

21502

14133

	1 - State Registrar Certificate of Death Reg. No.												
Physicia	n/	1. Decedent's Name (First, Middle			Cl = 1=	- 6		2. Date of Dea	ath Day	Year	3. Time of Death		
Medic	al	Phyllis	Jean		Schu			4	79	10	1.3/7 M		
Examin	er	4a. Facility Name (if not institution	i, give street and number)			4b. City, Town, o	FP/AN	D	4c. Co.	inty of Death	21)V		
Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	, Year)	Count	place (State or Foreign try)		
Director		213-24-6168 Usual Residence of Decedent	^	00				01/16/	1930	Mar	ÿland		
ryland I-f sho ied at	ctor	10a. State 10b. County		10c. City	, Town or Lo					10	0d. Inside City Limits 1 Ty Yes 2 No		
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s 23a	Funeral Director	1502A E. Oldt	own Road			2	1502			USA			
r item iner m		11. Marital Status	12. Was Decedent Armed Forces?			Vas Decedent of H f Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		Race - America Black, White, e			
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d Men marke matic	۴	Harry 19a. Informant's Name/Relations	Robert	M1	tchell		Maude	Irene		Jones			
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t of He If item or othe		20a. Method of Disposition 1 ☐ Burial 2 🏹 Cremation	3 ☐ Removal from State		lace of Dispo emetery, cren	sition (Name of natory or other plac	ce)	Date	20c. Location	on - City or To	wn, State		
irt. Pag irtmen irtant: njury o		4 Donation 5 Other (Specify)	Cum			ory 04/20				MD Home, P.A.		
permi Depar Impol any ir		21. Signature of Funeral Service I			- 1		tur Street		•		21502		
		23a. Part 1. Litter the diseas , or shock, or heart failure. List of	complications that caused only one cause on each line	d the death		1	/	W.			Approximate Interval Between		
Physician/ ⊬ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as		My	o Canoni	1 17	lanctin	<u> </u>		Onset and Death		
Examiner			Due to (or as	a consequ	ence oi):	S.	L						
D #	niner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying	Dille to (brids	a consequ	enes of;					=			
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	/Med	IF FEMALE:					- 2		-				
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Physic this ce al dire	မ	1 Yes 2 No 27. Manner of Death			ER/Outpatien		4 LJ Nursing Ho						
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To the Hospital or Attending Physician; The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendicompleted filled in by the funeral director, page 2 should be detached for use		202 Certifier 1 Certifying		/		accured at the time	date and place, on			opper as states	1		
n 24 ho	Medical	(Check 2 L Medical E											
withi Com		29b. Signature and title of certifier	11/1/			29c. Licenso	e number	:	29d. Date sig	ned (Month, D	ay, Year)		
6		00 November 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1/ is	looth (l)	020 (7)	1DJU	166		7-d	0-10	/		
nas		30. Name and address of person Vik Poon					mberland,	MD 21	502				
Stat	e	31. Date filed (Month Day Year)	32. Registra										

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 18:54 201 CMAKA Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE CITY UMUERSITY Medich MARYCHIO BALTIMURE Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 **X** M 2 □ F Months Hours Min. 1170971929 210-22-5474 80 Director PA Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director 1 X Yes 2 No MD TALBOT **OXFORD** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 408 SOUTH MORRIS STREET 21654 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc 1 Never Married 2 Married by Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 X Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour popartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical Decedent's Education 16b. Kind of Business Industry MISCELLANEOUS 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) **OWNER** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 EDGAR TOOMBS CORDELIA PARRY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PHYLLIS R. GAITI/COMPANION 408 S. MORRIS ST., OXFORD, MD 20a. Method of Disposition 20b. Place of Disposition (Name of CHESAPEAKE CREMATION 04/16/2010 CENTER 1 Burial 2 X Cremation 3 Removal from State STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P
200 SOUTH HARRISON STREET, EASTON, MD 21601 2 MERCERO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical to (or as a consequence of **Examiner** Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Month Pregnant at time of death 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed Completed by be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy performe 1 Yes 2 No Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Director: After Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours after To the Funeral Dire To the Hospital Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number

State Registrar

G+VA

ame and address of person

31. Date filed (Monta)

completed cause of death (Item 23a) (Type, Print)

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ARMOND KEITH TENNIER APRIL 19 2010 11:50 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 121 SONATA WAY CENTREVILLE QUEEN ANNE'S 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 **X** M 2 □ F MAY 14, Year 36 Director 73 CALIFORNIA 570-42-1721 Usual Residence of Decedent shov 10a. State 10b. County traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits 28a-f s 1 ▼ Yes 2 □ No CENTREVILLE QUEEN ANNE'S MD Ö 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 23a Funeral USA 121 SONATA WAY 21617 items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Race - American Indian, Armed Forces?
1 X Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ò þ 1 Never Married 2 X Married hours after Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify. "natural" Completed 3 Widowed 4 Divorced Year or Dates 954-1981 WHITE Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry uld be filed witting.

d Mental Hygiene. (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) COMMUNICATIONS U.S. COAST GUARD 12 marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည SHIRLEY HOFFMAN ARTHUR TENNIER of Health and Me of Health and Me fitem 27 is mark rother traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 121 SONATA WAY, CENTREVILLE, MD 21617 MARLENE TENNIER/ WIFE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State APRIL 21, CHESAPEAKE CREMATION
CENTER STEVENSVILLE, MD 4 Donation 5 Other (Specify) 2010 Signature of Funeral Service License FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) MANY YEARS CHRONIC OBSTRUCTIVE PULMONARY DISEASE Medical Due to (or as a consequence of) Examiner Eagueritany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated eaguer). Examine Due to (or as a consequence of) sician and burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical Box 68760 attending as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Pregnant at time of death 5 Other (specify) Year hed by the a detached f 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been signe should be c Records, 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 X No Hospital or Attending Physician: The certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2 🗶 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural injury work? 5 Pending Accident 2 \square No Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State)

nours after death neral Director: A I filled in by the f To the Hospital of within 24 hours a To the Funeral Completed filled is

State

Medical

(Check only one)

MARGARET D.

29b. Signatu

3

Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MALARO, M.D.,

32. Registrar's Signature

X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

202 COURSEVALL DR., SUITE 101, CENTREVILLE, MD 21617

29d. Date signed (Month. Day, Year)

4/20/2010

29c. License number

D0055127

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nnifer L. Timr	1- For State Certificate of Death										
Physici edical Exam		1. Decedent's Name (First, Middle JENNIFER L.						2. Date of De Month April 15,	Day Year	3. Time of Death 1006 hrs	
		4a. Facility Name (if not institution Atlantic General Hospi	n, give street and num	ber)		Berlin	or Location of De		4c. County of Worceste		
Funeral Director		5. Social Security Number 214-98-5364	6. Sex 7	. Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Ye Months Da		Min		9. Birthplace (State or Foreign Country) MD	
nd ibow any se.	Ļ	Usual Residence of Decedent 10a. State 10b. County DELAWARE SUSSI	EX		Town or Locati	on				10d. Inside City Limits	
ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 30662 PINEY N	ECK ROAD			10f. Zip Code	39		10g. Citizen of What	•	
after death wi al", or items ner must be	by Funeral		1 Yes orced If Yes, Give Year or Dates:	2 X No	lf Y∈	es, specify Cuba $_{ m Yes}$ 2 ${f X}$ N	n, Mexican, Pue o s <i>pecify:</i>		White, Specify:	WHITE	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours ment of Health and Mental Hygiene. anti: If item 27 is marked other than "natur: or other traumatic event, the Medical Exami or other traumatic.	Completed	15. Decedent's Education (Specific Elementary/Secondary (0-12)	College (1-4		during mo	t's Usual Occupa ost of working life EMAKER			16b. Kind of Busi	ness/Industry	
MD 21215-0036 d 2 should be filed within 77 Ith and Mental Hygiene. n 27 is marked other than numatic event, the Medical	o Be Co	17. Father's Name (First, Middle, EUGENE JENNII 19a. Informant's Name/Relationsh	NGS		10h Mailing	Addross /She	REBECC	CA WARNEI	, Maiden Surname) R umber, City or Town,	State Zin Code)	
ore, MD 21 es 1 and 2 should of Health and Me If item 27 is ma	ř	JAMES D. TIMMOI			30662		NECK RD.		ORO, DE 19		
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		1 Burial 2 X Cremation 4 Donation 5 Other Special Signature Floriera Service L	ecify:		PETALORIA REMATOR	Y		19-2010		RD, DELAWARE	
Physician	٤	23a Cost . Enter the disease, or o	complications that cau	sed the death.					LTD KFORĎ, DE rrest, shock, or hear	t Approximate Interval	
/Medical Examiner		failure, List only one cause of Immediate Cause (Final disease or condition resulting in death)	a. Pulmonary T							Between Onset and Death	
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	b. Due to (or as a co	onsequence of	n):						
be executed ician and urial - transit	dical Exar	events resulting in death) Last Due to (or as a consequence of): d. UNPENDED AMENDED									
8760, ificate be e ig physicial	n/Medio	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, ou	tcome of pregr		al death 3	Ectopic preg	anancy	23d. Date of do	elivery Day Year	
Box 68760, ne death certificate by the attending physic hed for use as the bur	Physician/Me	past 12 months? 1 Yes 2 ✓ No 9 Unkr	nown 9 Unknow	nt at time of dea	ath 5 Oth	er (Specify)					
Is, P.O. quires that then signed by	by	Part II. Other significant condition	ons contributing to d	eath but not re	esuiting in the ui	nderlying cause	given in Part I.		es 2 ✔ No 3	ute to the cause of death? Probably 4 Unknown pre autopsy findings available	
Recorc: The law reficate has be	Completed							auto perf 1 ✓ Yes	opsy prid formed? dea	or to completion of cause of ath? Yes 2 No	
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the brompletely filled in by the funeral director, page 2 should be detached for use as the brompletely filled in by the funeral director, page 2 should be detached for use as the brompletely filled in by the funeral director, page 2 should be detached for use as the brompletely filled in by the funeral director, page 2 should be detached for use as the brompletely filled in by the funeral director, page 2 should be detached for use as the brompletely filled in by the funeral director.	on: To Be	25. Was case referred to medical examiner? 1 V ves 2 No 27. Manner of Death 1 V Natural 5 Pendii	28a. Date of (Month, D		ER/Outpatient 28b. Time of In	3 DOA jury 28c. Inju	ury at Work?	sing Home 5	Residence 6 how injury occurred	Other:	
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the I	Certification;	2 Accident Invest	not be 28e. Place of	of Injury - At ho	ome, farm, stree	t, factory, office	Yes 2 No	28f. Location or Town,		or Rural Route Number, City	
To the Hosp within 24 ho To the Fune completely fi	Medical C		ysician: To the best on the basis of and manner state	examination an							
H 2 H 3	Me	29b. Signature and title of certifier				29c. Licen: O.C.			29d. Date signed April 16, 201	(Month, Day,Year)	
E.J.4		30. Name and address of person v Donna M. Vincenti, MD	Assistant Me	dical Exam	niner 111	Penn Street	, Baltimore,	MD 21201			
St Regist	tate	31. Date filed (Month, Day Year)	2010 32/Regi	strar's Signatu	ban	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Christine E. Thompson Physician/ 19 April ,2010 12:45p Medical 4a. Facility Name (if not institution, give street and number)
SouthernMarylandHospitalCenter **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Clinton, Maryland PrinceGeorge's 8. Date of Birth (Month, Day, Ye Sept. 29 5. Social Security Number 577-52-6176 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Hours Wash., D.C. Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Md. P.G. Temple Hills, Md. Yes 2 No 10f. Zip Code 20748 10e. Street and Number 3607 Dixon Street 10g. Citizen of What Country? Funeral U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Was Deced Armed Forces? 14. Race - American Indian 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3 Divorced 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) DayCare Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Brown Richard Mary C. Fletcher 19a. Informant's Name/Relationship (Type, Print) Husband Hewitt J. Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3607 Dixon Street Temple Hills, Md. 20748 20b. Place of Disposition (Name of cemetery, crematory or other place)
Resurrection 20a. Method of Disposition 20c. Location - City or Town, State April25,10 Clinton,Md. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Flineral Service Lice 22. Name and Address of Facility Wash p 2 2 2 0 0 0 1 Robinson Funeral Home 13 13 6th St.NW 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final KESPIRATOR: Physician/ disease or condition resulting in death) Medical Examiner Due to (or as a consequence of) Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Cause (Disease or iinjury Examine PNEUMONIA Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and dbe detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an nas autopsy perform death? certificate | 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA after death.

Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural
Accident
Suicide 5 \square Pending 1 Yes 2 No Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours edical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) APRIL 20TH 2010 se of death (Item 23a) (Type, Print) Date filed (Month, Day, Year) State APR 2 2 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last)
ELBERT VOORHEES, 2. Date of Death 3. Time of Death Physician/ 0424 M 04 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NICOMICO MINSULA 544554M 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours Min. 1-(18th, 1945ar) NEW JERSEY **Director** 143-34-9215 65 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 1 Yes 2X No SUSSEX DELAWARE SELBYVILLE 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 38286 MAPLE LANE 19975 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: WHITE "natural" Completed 3 Divorced 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) BUSINESS OWNER/OPERATOR the state SUB SHOP event, Be 18. Mother's Name (First, Middle, Maiden Surname)
ELLEN ELIZABETH AUSTIN 17. Father's Name (First, Middle, Last) of Health and Mental H ဂ္ ELBERT VOORHEES, JR Department of Health and Ment Important: If item 27 is marke any Injury or other traumatic e 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY A. VOORHEES / WIFE 38286 MAPLE LANE, SELBYVILLE, DE. 19975 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Page 1 1 Burial 2 X Cremation 3 Removal from State MELSONS CREMATORY 4-20-2010 FRANKFORD, DELAWARE 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Fundal Service Licensee Melson funeral services, Ltd 43 Thatcher St, Frankford, De. 19945 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or real failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ HEART FALURE CANCESTE! Medical Due to (or as a consequence of) **Examiner** JEEKS MURRALVANIE Sequentially list conditions, if any, leading to immediate cause. Enter chaerlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last signed by the attending physician and be detached for use as the burial-transi Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death g ☐ Unknown 5 Other (specify) g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕡 Unknown Records, CALDIO MORATA 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? 1 Yes 2 No 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 1 Natural injury work?
1 Yes 2 No 5 Pending death. 2 Accident Investigation hin 24 hours after death the Funeral Director; completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 29c. License number MAL 20, 2010 who completed cause of death (Item 23a) (Type, Print)

State Registrar 30. Name and address of p

20 2010

10-03044	
Julie Vlado	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lulie Vlado	State of Maryla 1- For State Registrar	and / Department o Certificate o		ar mygiene Reg.	No. 2010	4139	
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Julie P. Vlado		24	2. Date of Death Month E April 19, 201	Day Year	3. Time of Death 0740 hrs	
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of D				4c. County of Death Prince George	's	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.			24Hrs. 8. Date of Birth	(MM/DD/YYYY) 9. Birth	nplace (State or Foreign	
	214-87-3108 _{1 M 2} X _F	Min. 12-28-	-09 Vi	rginia			
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits						
laryland 28a-f show at once.	MD Prince George's Greenbelt 1 X Yes 2 No					77	
tiffied Dir					uy:		
r death with or items 23 must be no Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Or If Yes, specify Cuban, Mexica				14. Race - Americ White, etc.		
s after d	3 Widowed 4 Divorced If Yes, Give Yes or Dates: 15. Decedent's Education (Specify only highest gra	Yes 2 No specify:			Specify: White 16b. Kind of Business/Industry		
5-0036 ed within 72 hour 1/9 giene. other than "natu the Medical Exan		1-4 or 5+) during	most of working life. DO NOT us			iddotty	
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica Be Comple	17. Father's Name (First, Middle, Last)	infant		Name (First, Middle, Ma	infant iden Surname)		
1215. be filed ental Hy rrked of vent, the Be C	Micheal Vlado Norwe			wel Demit	l Demitro		
MD 21 2 should 2 should th and Me 27 is ma matic ev	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6912 Hanover PKWY Greenbelt, MD 20770						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medic To Be Compl	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal for		osition (Name of cemetery, other place) Of Heaven		20c. Location - City or Sliver Sp		
Saltim ermit. Pa epartmen nportant ijury or o	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	22.	Name and Address of Facility	A.Sanders	&Sons Moi	ruary	
Physician	13329 Woodbridge ST Woodbridge, VA 2219 3a. Part I. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Returned Open.						
/Medical. /Examiner		bronchopneumo	nia			Between Onset and Death	
	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):						
niner							
Exar Exar	events resulting in death) Last Due to (or as a consequence of): d.						
50, te be executed bysician and burial - transit	X UNPENDED AMENDED 23a, 27, per EM g904 6/3/10 TT						
6876(rtificate ing phys as the b	IF FEMALE: 23c. If yes, 23b. Was decedent pregnant in the past 12 months?	outcome of pregnancy	etal death 3 Ectopic p		23d. Date of delivery Month D	ay Year	
X = 5							
P.O. B s that the d gned by the e detached by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown						
cords, Plaw requires that been sign 2 should be confident				24a. Was an	24b. Were aut	opsy findings available	
Records, The law requirer ficate has been sig				autopsy perform	ed? death?	ompletion of cause of	
ital Recition: The lician: The lician: The licians vertificate lector, page	25. Was case referred to medical examiner?		26.Place of Death (C				
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the rape death. The law requires that the rape of the reduction of the this certificate has been signed by led in by the funeral director, page 2 should be detact ertification: To Be Completed by P	1 V Yes 2 No 27. Manner of Death 28a. Date of Injury (Month Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred						
Sion Attendir death. sctor: A sy the fu	1 X Natural 5 Pending 2 Accident Investigation 2 Recorded Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City						
Division c spital or Attending hours after death, neral Director: Af filled in by the fun Certification	Suicide b Could not be determined (Specify) or Town, State)					ar route rumber, only	
Division of Y To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Aftert completely filled in by the funeral Medical Certification: T	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 V Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)						
To the within To the comple	29b. Signature and title of certifier 29c. License number 29d. Date signed (Mon						
		April 20, 2010					
	30. Name and address of person who completed cause of leath (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201						
State	31. Date filed (Month, Day, Year) 32. R	egistrar's Signafure	2				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Kenneth Marlow Wallizer 1:12 PM 2010 April Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany 13426 Rocky Gap Road Cumberland Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 1 😾 M 2 □ F Days Hours Director 90 220-10-9268 03/31/1920 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b, County 10c. City. Town or Location 10d. Inside City Limits Director MD Allegany Cumberland 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13426 Rocky Gap Road 21502 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 1 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: 3 Widowed 4 Divorced Year or Dates. WWII White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Electrician Union Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Grant McKinlev Wallizer Susanne Marie Bennett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Wallizer / Wife 13426 Rocky Gap Road, Cumberland, MD 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sunset Memorial Park 05/01/2010 Cumberland 22. Name and Address of Facility Adams Family Funeral Home, Signature of Funeral Service Licenses 404 Decatur Street, Cumberland, 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final TEDIOMYOPAT H Ph sician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Physician/Medical Examiner Due to for as a consequence of if any, leading to immedia cause. Enter Underlying attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year 5 Other (specify) Pregnant at time of death ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DECU BITUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; After this certifica completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 PResidence 6 Other (Specify) 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending 1 Natural work 1 Tes 2 🗌 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check To the I within 2 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature d title of certifier 29d. Date signed (Month, Day, Year) D0064167 April 28, 2010 3+1 Clairan 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print) Noshin Qaisrani, M.D. 600 Memorial Avenue, Cumberland, MD 21502 Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav REBECCA SUSAN WEAVER OU Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Cumberland Western MD Regional Medical Center Allegan Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours 1 □ M 2 🕱 F Months Min. 02/06/1948 235-74-1919 Director 62 MARYLAND Usual Residence of Decedent Show Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director WV MINERAL 1 Yes 2 No RIDGELEY 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral ROUTE 1, BOX 504 26753 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian, Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced WHITE Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည DANTEL COLLINS REGINA PAYNE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LAWSON DALE WEAVER / HUSBAND ROUTE 1, BOX 504, RIDGELEY, WV Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State ō permit. Page Department of Important: If any injury or once. 4 Donation 5 Other (Specify) CEMETERY 04/27/2010 RIDGELEY, WV 21. Signature of Funeral Service 22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET, CUMBERLAND, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw shock, or heart failure. List only one cause on each line. OVARIAN Immediate Cause (Final Physician/ ARCINOM + disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician. The law requires that the death certificate be executed the attending physician and thed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Order (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Month Year 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be de ۾ ا 1 Yes 2 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perforn certificate 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No မ 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this hin 24 hours after death.

the Funeral Director: After thi

npleted filled in by the funeral 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No . Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident
Suicide Investigation
6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined within 24 hours a Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [only one) 29b. Signature and title of certifier 3 son who completed cause of death (Item 23a) (Type, Print) 2500 31. Date filed (A State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Joseph L. Wright Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Allegany Western Maryland Regional Medical Center Cumberland Social Security Number If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs, last birthday, If Under 1 Year 8. Date of Birth **Funeral** Sex. 1 M 2 □ F (Month, Day, Year) August 30, Days Min Director 216-38-1360 1938 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I frem 27 is amarked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 🗌 Yes 2 🎽 No Allegany Frostburg Maryland ۵ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17030 Porter Road, N.W. Funeral U.S.A. 21532-11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 ☐ Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed 3 Widowed 4 Divorced Specify. White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) maintenance department county government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Wright Margaret Brode 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Crowe 21528sister P.O. Box 104 Maryland **Eckhart Mines** 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Eckhart Cemetery April 21, 2010 Eckhart Maryland 21. Signature of Funeral Service Licer 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ my ocardi. Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to or as a consequence of burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) 2/1 No မြ 1 Tes 1 → Papatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Natural Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending injury To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nos 31. Date filed (Month, State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Degedent's Name (First, Middle, Last) 2. Date of Death nonth. Physician IMP 210 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Lanham Rexford Place

5. Social Security Number 6. Sex Georges Prince 8. Date of Birth (Month, Day, If Under 24 Hrs. I 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Year) Hours Months 1 □ M 2 😾 F Director 438-28-0405 89 Louisiana 30,1921 Usual Residence of Decedent with the Maryland 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mydical Examiner is ust by notified at once. 1 ☐Yes 2 ☐ No Director MD Lanham 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number U.S.A Funeral 20706 9885 Greenbelt Rd 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No 2 SpecifyBlack 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Social Service Supervisor Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Wilbert Herbert Davis Nellie Norman 19a. Informant's Name/Relationship (Type. Print) 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2505 Medinah Ridge Rd. Accokeek MD. 20607 Cornelius Wilson Jr. Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/22/10 Cheltenham 4 Donation 5 □ Other (Specify) MD. Vet. Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hodges and Edwards 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 3910 Silver Hill Rd.Suitland, Md. 20746 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off: Examine The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. ned by the 9 Unknown 9 Unknow certificate has been signed irector, page 2 should be del Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe 1 ☐ Yes Attending Physician: e Hospital or Attending Physician: 24 hours after death. e Funeral Director; After this certific letely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\to\) Nursing Home \(\frac{1}{2}\) Residence \(6 \) Other (Specify) Hospital: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ပ 28a. Date of Injury Certification: 27. Manner of eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred **Natural** 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. within 2 To the 29b. Signature and title of certile 29c. License number 29d. Date signed (Month, Day, Year) 2

State Registrar 30. Name and address of person who completed cause of death (Item, 23a) (Type, Print)

31. Date filed (Month, Day, Year)

32. Registrar's Signature

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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mgnth Zamagias Sara Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cumberland Allegany WMHS-RMC 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Funeral 1 □ M 2 □ F Months Hours Nov 29 **Director** <u> 190-26-1802</u> Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits **Funeral Director** MD Cumberland Allegany 1 XYes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 21502 USA 243 Utah Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 1 Tes 2 No Specify: If Yes, Give Year or Dates Specify: 3 Divorced 4 Divorced Completed white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) own home homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frank Berkebile Helen (Noon) Berkebile 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 243 Utah Avenue Cumberland MD 19a. Informant's Name/Relationship (Type, Print) MD 21502 husband James Zamagias 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Grandview Cemetery 1 X Burial 2 Cremation 3 Removal from State 4/19/201b PA Johnstown 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sept 22. Name and Address of Facility ral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Par 1. Enter the disease, o/complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest six ck, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ ARDIOGENIC disease or condition Medical resulting in death) Examiner INFARCTION HOUTE MUDGARD INL Dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ANGURYSM ADRTIC 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes Other: မြ 1' Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 only one) APRIL 15,2010 aum M 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2501 WILLOWBROCK RD CLIMBERLAND MD 21502 WILLIAM LAMM MID. I 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

10-03247	
Matthew Amory	

tthew Amory	State of Maryland / Department of Healt 1- For State		giene Reg. 1	2010	14145
Physician/ edical Examiner	Decedent's Name (First, Middle,Last) Matthew Keaton Amory		2. Date of Death Month Da April 27, 2010	ay Year 0	3. Time of Death 0915 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, To University Hospital Baltim	own, or Location of Death		4c. County of Death	
Funeral Director	$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$		8. Date of Birth(N 02–26–19	95 9. Bir Op5 Co	
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
ryland a-f show t once,	MD Howard Ellicott 10e. Street and Number 10f. Zipo		I 10g (Citizen of What Cou	Yes 2 No
h the Maryland 3a or 28a-f sh otified at once		042	log. v	USA	,
ter death with ", or items 23 er must be no		nt of Hispanic Origin? (Spect Cuban, Mexican, Puerto Ri		14. Race - Ameri White, etc.	can Indian, Black,
5-0036 ed within 72 hours aft tygiene. other than "natural" the Medical Examine Completed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual C	Occupation (Give kind of wor ling life, DO NOT use retired	d)	b. Kind of Business/I	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	17. Father's Name (First, Middle, Last) Reginald B. Amory	18.Mother's Name (F Valerie		len Surname)	
AD 21 2 should to and Mer 27 is mar matic ever		(Street and Number or Rur d Valley Rd.			
more, Nages I and ent of Health nt: If item	20a. Method of Disposition 1 ABurial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name crematory or other place) Meadowridge Mem			oc. Location - City or Clkridge,	
Baltir permit. 1 Departme Importa injury or	21. Signature of Funeral Service Licensee 22. Name and A	North Ave. B			2
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of failure. List only one cause on each line. Immediate Cause (Final disease a. Asphyxia	dying, such as cardiac or re	espiratory arrest, s	shock, or heart	Approximate Interval Between Onset and Death
Examiner	or condition resulting in death) Due to (or as a consequence of): Hanging				
miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	****			
TO I	events resulting in death) Last Due to (or as a consequence of): d.		· · · · · · · · · · · · · · · · · · ·		
6 be executed sysician and burial - transit	UNPENDED AMENDED				
ox 6876 wh certificat titending phy or use as the sician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (Specif	3 Ectopic pregnanc		23d. Date of delivery Month E	y Day Year
ires that the des signed by the a detached for	Part II. Other significant conditions contributing to death but not resulting in the underlying of	ause given in Part I.		co use contribute to	_
ords, P. w requires th s been signe should be de			24a. Was an		topsy findings available
of Vital Records, ng Physician: The law requires the this certificate has been signeral director, page 2 should be no. To Be Completed	25. Was case referred to medical 26	6.Place of Death (Check onl			ompletion of cause of
F Vital Physician r this cert al directo To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DO	A Other Nursing H	Home 5 Resi	idence 6 Other	:
ion of tending Pleath. tor: After the funera	(Month, Day, Year)		3d. Describe how i ubject hanged		
Division of Vital I Hospital or Attending Physician: Py hours affected. Py Hoursal Director: After this certificely filled in by the funeral director,	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, or (Specify) Single Family		or Town, State)		ral Route Number, City bia , MD
Hi hi the	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my one and manner stated,				
To with To com	29b. Signature and title of certifier	O.C.M.E.		d. Date signed <i>(Mor</i> pril 30, 2010	nth, Day, Year)
₹ ✓	30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Stre	et, Baltimore, MD 21	1201		
State Registrar	31. Date filed (Month, Day, Year) 32 Registrar's Signature				

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Dilip Rambahi Amin State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month D. May 2, 2010 **Medical Examiner** 0509 hrs Dilip Rambhai 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Laurel Regional Hospital Prince George's 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Days Hours Director Months Country) India 1 X M 2 F Yrs 083-48-2891 66 08-18-1943 Usual Residence of Decedent ıny 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits 28a-f show 1 Yes 2 No narked other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. MD Howard Laurel Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9613 Jester Court 20723 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? 1 Never Married 2 X Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 X No Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: Asian Indian ð 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Nuclear Medicine Technician Medicine 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be Rambhai Javerbhai Amin Kambraben Patel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Biren Dilip Amin / Son 9613 Jester Court Laurel, Maryland 20723 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State t: If it Burial 2 K Cremation 3 Removal from State Donation 5 Other Specify 05-06-2010 W. Arundel Crematory Odenton, Maryland Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.

Pond Odenton, Maryland 21113 cure of Funeral Service Linus Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Appr **Physician** failure. List only one cause on each line Between Onset and /Medical Atheorsclerotic cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending nhysician and and Physician/Medical AMENDED 23a,27,per ME G905, 7/1/10 TT X UNPENDED attending physician or use as the burial Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part IL Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? this certificate ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other 1 🗸 Yes 2 No After Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 X Natural neral Director: filled in by the f 5 Pending 1 Yes 2 No Accident 2 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E May 3, 2010 30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, 2. Registrar's Signature Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #9 & 10e, per Fh g903 5/6/10 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.) 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 150 am 10 /Medical 4b City, Town, or Location of Death 4c. County of Death Name (If not institution, give street and number) Examiner 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 9. Birthplace (State or Foreign Social Security Number Age (In yrs. last birthday) **Funeral** Months Hours Min Yrs. North Carolina Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Baltimore 1 Yes 2 No Director 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code USA 2 Iron Gate Court death v Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1 es 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired)

Ki99CF permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Stec. 18. Mother's Name (First, Middle, Maiden Surn 17. Father's Name (First, Middle, Last) Doug 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Boute Number, City Northyate Road Nephew 1429 Maryland Buie Baltimore. 20b. Place of Disposition (Name of 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place) 3 Removal from State Forest Jarrison 21. Signature of Funeral Service Licensee (!. Greene F.S. Vork Road Raltimore, Md 21212 MO1553 Vaughn 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ngestrue /Medical Due to (or as a consequence of): Examiner Corner arting Sequentially list conditions, in any, leading to in-module cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last tia to (or 95 if consequence of): Examiner burial-transit and Due to (or as a consequence of): P.O. Box 68760, attending physician pe Physician/Medical the as IF FEMALE: for use a 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed funeral director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy rmed? 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending P 4 hours after death. Funeral Director: After t Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Hospital of within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) completely and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 37 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Reistentown RD. 2121 DARSHAN.S. SALUIA 6821 0 6 2010 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** TRIC 04 20/0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. <u> Anne Arundel Medical Center</u> Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□ M 2□ F Yrs 504-50-0074 79 **Director** 04-10-1931 Montana Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examples must be matified at Director 1 ☐ Yes 2 X No MD Anne Arundel Gambrills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 938 Falls Circle Way Completed by Funeral 21054 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2X No Specify: 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Teacher Education 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ပ Chester Clark Esther Steed 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Brune / Daughter 48840 MacArthur Blvd. NW Washington, DC 20007 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arundel Crematory 05-04-2010 Odenton, Maryland 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A. 21. Signature of Funeral Service Licensee 1411 Annapolis Road Odenton, Maryland 21113 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ERITONI disease or condition resulting in death) /Medical Due to (or as a consequence-of) STER CORAL ULLER Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 1 □ Yes 2 □ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To → Inpatient 2 ER/Outpatient 3 DOA eral Director: After th filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral TCCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. within 2 To the 29b. Signature and title of pertifie 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) ANNAPOLI) un Ca Year) 32. Registrar's Signature 31. Date filed (Month. State 6

DHMH 17 Rev 1/2001

Registrar

		Ame	end #26, per MD	g903 5/6/ State of	/10 TT of Marylar				and M	ental Hy	gien	e Legible.	11110
			For State Registrar			Ce	rtificate of	Death		0.5.1.7.5	Reg. N	KU I U	14145
4	Physici	an	Decedent's Name (First, Midd		·		Boyd			2. Date of Do Month	_ D	ay Year	
1	/Medic		4a. Facility Name (If not institution		Mae		4b. City, Town,	or Location of	of Death	May	5,	2010 lc. County of Dea	8:24 A
	Examin		7419 Hill Con	_	7. Age (In yrs.	last hirthday		nda1k		8 Date of Bi			Baltimor
	Funeral Director		281-26-6297 Usual Residence of Decedent	1 M 2 X F	78	Yrs.	Months Days		Min.	8. Date of Bi (Month, D June			rthplace (State or Foreig Country) st Virginia
	yland now at		10a. State 10b. Count	У	10c. Ci	ty, Town or Lo	ocation						10d. Inside City Limit
	e Mar a-f st tified	cto	MD	Baltimore	e					1	Dund	la1k	1 ☐ Yes 2 📉 N
	th with th 23a or 28 ist be no	al Dire	10e. Street and Number 7419 Hill Co	urt			10f. Zip Code	212	22			Ditizen of What Conited Sta	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: I filem 27 Is marked other than "natural" or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Ma 3 □ Widowed 4 □ Divorce	rried Armed F	.2 Mo ive		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 🕅 No		gin? (Spe ı, Puerto I	cify Yes or N Rican, etc.)	0-	14. Race - Am Black, Whi Specify:	
ڻ ص	72 h "natu dical	etec	15. Decede (Specify only high	nt's Education est grade completed,)	16a. Dece	dent's Usual Occi kind of work don DO NOT use retir	ipation during mos	t of workir	ng	16b.	Kind of Business	s/Industry
21215-0036	ed within ygjene. ier than ' t, the Me	Compl	Elementary/Secondary (0-12) 10 Years		(1-4or 5+)		nemaker					Own Home	2
Maryland	be fill stal H ed oth even	To Be	17. Father's Name (First, Middle	,						(First, Middle E. Ni		en Surname)	
2	hould d Mer marke	ြ	Gilpen F. Gand 19a. Informant's Name/Relation			19h Maili	ng Address (Stree					var Tawn State	Zin Cada)
<u> </u>	nd 2 s ulth an 27 is i		Karen Capaldi)		3 Yorkwa			, Mary			
ē,	S 1 ar		20a. Method of Disposition		20b.	Place of Dispo	osition (Name of matory or other pi	i		ate	7	Location - City o	
Baltimore,	Pages nent of hant: If ite		1X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (State	-	n Cemete	1	5/8/:	2010	Ι τ	201+imor	e. Maryland
<u>=</u>	rmit. porta porta y Inju		21. Signature of Funeral Service	Licensee		2	2. Name and Add	ess of Facilit	v	1111-200-			
m	8 8 E 8		Pula -	7 V/es	-		Ouda-Rucl 7922 Wis	e Ave	Du	ındalk.	Ma	ryland	inc. 21222
) F	Physician /Medical	i n	23a. Part1. Enter the disease, shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	a	caused the dear each line.	ar Co	ter the mode of dy		cardiac o	r respiratory a	arrest,		Approximate Interval Between Onset and Death
	Examiner	ē	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a consec	juence of):							
oo,	oe executed cian and ourial-transit	Ä	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a consec	juence of):							
08/0	cate r physic the b	dica		d									
P.O. Box	I ne law requires mat the death cermicate be tite has been signed by the attending physicia bage 2 should be detached for use as the bur	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	1 ☐ Live	utcome pf pregn birth 2 □ Feta nant at time of d nown	aldeath 3[□Ectopic pregnan □ Other (specify)	су				23d. Date of de Month	elivery Day Year
, L	iw requires that is been signed by should be detail	by	Part II. Other significant condit	lons contributing to d	death but not res	ulting in the u	nderlying cause g	iven in Part I.					to the cause of death?
	requ	eted											
		Completed								24a. Was auto perf 1 Yes	s an opsy ormed?	death?	
NEG !	rnysician: this certific ral director,	Be	25. Was case referred to medic examiner?	Hospital:			_ 10	hor:		(Check only		- H	1
5	ald ald	2	1 ☐ Yes 2 No 27. Manner of Death	28a. Date	of Injury	ER/Outpatie	" O DOY	4 □ Nu		ne 5 XRes		Other (Sp jury occurred	ooity) Hospice
5 :	rending Fin leath. tor: After th the funeral	tion	Natural 5 Pendi	ng (Mor igation	nth, Day Year)	Injury	f 28c. Inj W M 1 [ork?]Yes 2∐I				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
DIVISION	after dea Director d in by th	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ningd 28e. Plac	e of injury - At h ding, etc. (Speci	ome, farm, st fy)	reet, factory, office		2	8f. Location City or To	(Street own, Sta	and Number or F ate)	Rural Route Number,
	I of the hospital of Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Medical C	29a. Certifier (Check only one) Certify 2 Medica	ng Physician: To the I I Examiner: On the I and mar	e best of my kno basis of examina nner stated.	owledge, deat ation end/or in	h occurred at the overtigation, in my	time, date an opinion, dea	nd place, a ath occurre	and due to the ed at the time	e cause e, date a	(s) and manner a and place, and du	as stated. ue to the cause(s)
	withir Comp	Me	29b. Signature and title of certifi	er			29c. Licer	ise number	, , ,	0	29d. E	Date signed (Mor	nth, Day, Year) -
)			1 200	Nes	MD		_	506		\neg	Ma	45,20	010
			30. Name and address of person	who completed cau		n 23a) (Type,	Print)	no B	alti	MON!	Mr) 8133	24
			31. Date filed (Month, Day, Year	U T	Registrar's Signa		· 11 CM	we ke	~111	11 MAC	A 7	, 0.00	

DHMH 17 Rev 1/2001

		_	For	State of	of Maryla	-			d Mental Hy	giene	0 11 150
]	State Registrar			Cer	tificate of D	Death		Reg. No.	U 4 5U
Phys	siciar		1. Decedent's Name <i>(First, Middle, L</i> Pauline		cino B	ridges	•		2. Date of De Month May	Day 201	aar 3. Time of Death 7:55 P M
	edica ımine		Faulline 4a. Facility Name (if not institution, g			ridges	4b. City, Town, or	Location of De		4c. County of E	
Exa	Ш	ali	Gilchrist Nurs		, and the second	tr.		owson			more Co.
Fune			5. Social Security Number 6	. Sex 1 ☐ M 2 汉 F		. last birthday)	If Under 1 Year Months Days	If Under 24 H		th 9.	Birthplace (State or Foreign
Direc			219-20-1057 Usual Residence of Decedent	I □ W Z X F	84	Yrs.		1.00.0	June	^y 18,1925	Mary land
and Show	i i	. t	10a. State 10b. County	•	10c. 0	City, Town or Lo	cation				10d. Inside City Limits
Maryla 18a-f		rect	MD Ba	ltimore			Edg	gemere			1 ☐ Yes 2 🔀 No
a or 2	De De		10e. Street and Number				10f. Zip Code			10g. Citizen of Wha	'
th with	mar.	Funeral Director	8505 North					21219		United S	
r deal	imer	by Fu	I1. Marital Status1 \(\subseteq \) Never Married 2 \(\subseteq \) Married	Armed Fo	edent Ever in l orces? 2 🔀 No	J.S. 13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? n, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - A Black, V	American Indian, White, etc.
S afte	Exau	g pe	3	If Yes, Giv Year or D	/e	1	☐ Yes 2X No	Specify:		Specify:	White
2 hour	dical	Completed	15. Decedent's (Specify only highest)		ent's Usual Occupa and of work done of		vorkina	16b. Kind of Busin	ess Industry
X1X13-UU30 within 72 hours after giene. than "natural", o	Je Me	Ĕ	Elementary/Seconday (0-12)	College (1		life. De	o NOT use retired) emaker	3		Own Ho	am e
C N Hygie other	ent, t	as F	12 Years 7. Father's Name (First, Middle, Las	t)		11011	ellakei	18. Mother's I	Name (First, Middle,		inc
yland Id be filed Mental Hy arked oth	ac ex	의	Norman Dronebur	g				0	neida Sum	mers	
Daltimore, IMaryland ZIZID-0030 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item ZI is marked other than "natural", or items 23a or 28a-1 show any inition or other training wash the Marklind Evanings must be notified at	anma		19a. Informant's Name/Relationship		*	19b. Mailin	g Address (Street a	and Number or	Rural Route Numbe	r, City or Town, State	e, Zip Code)
e, N and 2 : Health em 27	ne. ne		Mrs. Ann Sistek	. (Daug	ghter)			oint ko			land 21219
ge 1a nt of P	00.00	ľ	20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3		State	. Place of Dispo cemetery, cren	natory or other plac	e)	Date	20c. Location - Cit	y or Town, State nore, Maryland
Daltimor Dermit. Page 1 Department of important: If it	ulary	-	4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		Ua		Cemetery		7/2010		
Depart Depart	any in		21. Signature of Fulleral Service Lice	11=		ľ	uda-Ruck 7922 Wise	Funera Ave.	l Home of	Dundalk, Maryland	Inc. 212.22
			23a. Part 1. Enter the disease, or co shock, or heart failure. List only	omplications that	caused the de	ath. Do not ente	r the mode of dying	g, such as card	liac or respiratory ar	rest,	Approximate Interval Between
Ph, sicia			Immediate Cause (Final disease or condition	- 17	ROKE						Onset and Death
Medi Examii	_		resulting in death)	Due to	(or as a conse	equence of):					
	-	<u>.</u>	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a conse	editence of:					
ted nsit	į .		cause. Enter Underlying Cause (Disease or injury	Due to	(Or as a conse	equence oij.					
execu an and ial-tra		֡֟֜֞֜֟֡֡֡֡֡֡	that initiated events resulting in death) Last	C. Due to	(or as a conse	equence of):					
the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and moleca filled in by the funeral director and 2 should be detached for use as the burial-transit		dical Examiner		d							
eath certificat attending ph		ğ	F FEMALE:	22s Hugo ou	tooms of prog	nanov					
death ce	³ / ₂ .	Physician/Me	23b. Was decedent pregnant in the past 12 months?		Birth 2 Fe	etal death 3 🗌	Ectopic pregnanc Other (specify)	:У		23d. Date o Month	· ·
he de y the		iš L	1 ☐ Yes 2 ☑No 9 ☐ Unknown	9 🗌 Unk			(0,000,000,000,000,000,000,000,000,000,				
requires that the debeen signed by the should be detached			Part II. Other significant conditions	s contributing to o	death but not r	esulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	obacco use contribut	te to the cause of death?
quires quires en sig									_ 1 🗆	Yes 2 No 3	☐ Probably 4 ☐ Unknown
e law requires has been sig		Completed by			-				24a. Was autop	psy prior	e autopsy findings available r to completion of cause of
rical neco sician: The law sertificate has b	n l	5							perfo	ormed? deat	Yes 2 No
VILCAI ysician: s certific director.		Re l	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		7	Othe	ace of Death (C		· · · · ·	Specify) HOSPICE
9 Phy 9 Phy er this		<u>o</u>	27. Manner of Death	28a. Date	of injury	ER/Outpatier 28b. Time of	28c. Injury	/ at	1	dence 6 Other (S	ipecity) USPICC
Attending Pl r death. ector: After they we the funera		<u> </u>	1 Natural 5 Pending 2 Accident Investigation	tion	nth, Day, Year)	injury	M 1 □	Yes 2 No			
or Atte		Certificate:	3 Suicide 6 Could no 4 Homicide determine	28e. Place	e of Injury - At ing, etc. (Spec		et, factory, office		28f. Location (S City or Tox		r Rural Route Number,
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has t completed filled in by the funeral director age 2 s		<u>g</u> -	29a. Certifier 1 Certifying P	hyeician: To the	neet of my kno	wledge death o	occured at the time	date and place	e and due to the ca	use(s) and manner as	e etated
e Hos n 24 h e Fun	Poloc	Medical	(Check 2 Medical Exa	miner: On the ba	sis of examinat	ion and/or invest	igation, in my opinic	on, death occurr	ed at the time, date a		the cause(s) and manner stated.
To th within			29b. Signature and title of certifier		$\overline{)}$		29c. License		2-	29d. Date signed (M	
				EN.	//	~	D	6439	15	MAY 4,	2010
			30. Name and address of person wh		se of death (Ite	em 23a) (Type, F	rint)	LI OT	SIN B	INS RAITI	MME MA 2,201
	State		31. Date filed (Month, Day, Year)	RMAN 32. F	egistrar's Sign	nature A	V CHARL	t30/1	OWIE TO	UNICIPIED PROCESSION OF THE PR	MME, MI) 21204
	istra		MAY 06	2010 4	insun	p. 4	ace				

May 3, 2010

	David Wayne Br		1- For State	tate of Maryla	-	artment of		ind Ment	al Hy		Reg. No.	2.0	0	1415
A Script Search of Teaching Control of Teachin	Physicia		1. Decedent's Name (First, Midd	dle,Last)						2. Date of De	eath	V	3	. Time of Death
Building E4002 Austin Road Building E4002 Austin Road See 7.4pe (by yr. last stringly) See 1.2pe 1.5pe See 1.2pe 1.			David Wayne	e Brewner	r					April 27,	2010	Year		1140 hrs
Second Security Number Second Security Number Second Security Number Securit				· -	mber)								Death	
Section Control Cont	/		9	n Road			Aberdeen							
Control of the cont				6. Sex	7. Age (In yrs.	last birthday)			_	8. Date of I	Birth (MM/	(DD/YYYY) S	9. Birthp oreign	lace (State or
Description of Description Tool. Clinic	Director		262-33-5479	1XM 2 F	54	Yrs		ays nouis	IVIII I.	12-9	19			ry) RI
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Common Service Comm	With Spiene	E	. —	l ast)		JOOWII.	ilg All						LLIC)11
Barbi Copeland Daughter 456 Allen Dr., Cookeville, TN 38501 20. Marked of Disposition 1											111			
Barbi Copeland Daughter 456 Allen Dr., Cookeville, TN 38501 20. Marked of Disposition 1	212 Jid be Ment mark		19a. Informant's Name/Relations	Srewner ship (Type, Print)		19b. Mailing	Address (Str						State, Z	ip Code)
De to cor as a consequence off): Continue Februar		-1			ughter	1456	Allen	Dr.	Coo	kevi l	ا ۾ ا	7 מיים	850	11
Summary Committee Control Co	and and lealth item	- 1	20a. Method of Disposition		20b.	Place of Dispos	ition (Name of	cemetery,	000	Date	20c.	Location - Cit	ty or To	wn, State
Physician (and the proposal properties of the pr				_	•	•								
Physician (and the proposal properties of the pr	it. Pr	- 1			Ba	yview (cremat	Ory	4-3	0-10	JВа	ltimo	re,	MD MD
Physician Phys	Depa Depa	- 1	11-411	7. 1. 1. 3		21	O 4 1.74 7] @	Bra	dley-	Ash	ton F	une	eral Home
Examiner Part Description Description	Physician	-	23a. Part I. Enter the disease, or	r complications that ca	aused the death	n. Do not enter th	oe mode of dyin	I LOW S ng, such as ca	DT1 rdiac or	respiratory a	rrest, sho	ck, or heart	2	
The second continue of		Ų	failure. List only one cause	on each line.									- 1	
The straight of the straight o	Examiner	- 1					CICIOC	ic dar	u I O V	ascuit	4L D.	Locase	\rightarrow	
The straight of the straight o	_		Sequentially list conditions	b										
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FEMALE: FEMA	exect an an	<u>s</u>	UNPENDED	¬	0.7	- 00	0 5/7/1	0 ==						
The state of the		o F	IF FFMALF	23a If yes o	,2/,per	m,E g90	3 5///1	.0 TT			230	Date of del	livery	
The state of the	787 rtifica ing pl	an/	23b. Was decedent pregnant in t	ho —	-		al death 3	Ectopic	pregnan	псу			-	Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a Was an autopsy performed? 1 Yes 2 No 3 Probably 4 Unknown 24a Was an autopsy performed? 1 Yes 2 No No Yes 2 No Yes 2 No No Yes 2 No Y	ox 6 or use	Si		known		eath 5 Oth	ner (Specify)							
State State	B be dez	ڇ		19 Olikilo						00 D:				
State State	b.O.		Part II, Other significant condi-	tions contributing to	death but not r	resulting in the u	nderlying cause	e given in Pan	τ).	_	_			
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State State	Vita hysici this c	0		Hospital: 1 l	npatient 2	ER/Outpatient	3 DOA	Other _	Nursing	Home 5	Reside	nce 6 🗸 C	Other: S	cene
State State	of ng Pl					28b. Time of In	ijury 28c. In	jury at Work?	2	28d. Describe	how inju	iry occurred		
State State	tendi tendi tor:	읥	_ Fell	ding			1_	Yes 2	No					
23a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Tegistrar's Signature	VIS or At fiter d Direct in by	iji		28e Place	of Injury - At h	ome, farm, stree	t, factory, office	building, etc.	. 2			nd Number o	r Rural	Route Number, City
April 28, 2010 State 31. Date filled (Month, Day, Year) 32. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. 29c. License number O.C.M.E. 31. Date filled (Month, Day, Year) 32. Cegistrar's Signature 32. Cegistrar's Signature 33. Page filed (Month, Day, Year) 34. Cegistrar's Signature 35. Cegistrar's Signature 36. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number O.C.M.E. April 28, 2010	pital Disa	됬	4 Homicide dete	rmined (Specify)						or rown,	State)			
29b. Signature and title of certifier O.C.M.E. 29c. License number O.C.M.E. April 28, 2010 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Hos 24 ho Fun etely		(Check only											
29b. Signature and title of certifier O.C.M.E. 29c. License number O.C.M.E. April 28, 2010 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	fo the vithin fo the	ğ	2 🔻	and manner st		and/or investigati			urred at	tne time, dat				
30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Fegistrar's Signature		Σ	29b. Signature and title of certifie	er										Day, Year)
Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Fegistrar's Signature			Miles				0.0	C.M.E.			Apri	1 28, 2010)	
State 31. Date filed (Month, Day, Year) 32. Jegistrar's Signature	_	ŀ						10,000						
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature							treet, Baltin	nore, MD 2	21201					
			31. Date filed (Month, Day, Year)	2010 32. 6	gistrar's Signatu	In lane	Kel							

Charles Bragg	State of Maryland / Department of Health a 1- For State Certificate of Death Registrar		Reg. No. 2010 14 15 2
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Charles E. Bragg, Jr.	2. Date of De Month May 1, 20	Day Year 1505 has
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, Johns Hopkins Bayview Medical Center Baltimore	, or Location of Death	4c. County of Death
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yrs. 15 - 78 - 6725 1 Months 15 Months 15	Year If Under 24Hrs. 8. Date of B	irth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) -1964 MD
v any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
yland -f show once.	MD Baltimore		1 X Yes 2 No
the Maryland a or 28a-f sh tified at once	6833 Eastbrook Ave. 2122		USA
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1 Never Married 2 Married Armed Forces? If Yes, specify Cul	Hispanic Origin? (Specify Yes or N ban, Mexican, Puerto Rican, etc.)	White, etc.
iours afte		pation (Give kind of work done life. DO NOT use retired)	Specify: White 16b. Kind of Business/Industry
5-0036 ed within 72 hour tygiene. other than "natu he Medical Exan	Elementary/Secondary (0-12) College (1-4 or 5+) 10 Constructi		Construction
5-00 lled wit Hygien 1 other the M	17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle,	
2121 uld be fi Mental I marked : event,	Charles E. Bragg, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (St	Frances A. T	yler mber, City or Town, State, Zip Code)
MD d 2 shoulth and n 27 is summation	Father		timore, MD 21222 20c. Location - City or Town, State
Ore, ges l an it of Hea i: If itel	1 Burial 2 Cremation 3 Removal from State crematory or other place)		Baltimore, MD
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than njury or other traumatic event, the Medica To Be Comple	4 Donation 5 Other Specify: Day VIEW CI et la 22. Name and Addr	- I	Ashton Funeral Home
ம் இத்தித் Physician	2134 Will 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dyl	llow Spring Ro	ad, 21222
/Medical Examiner	failure. List only one cause on each line. Immediate Cause (Final disease a. Acute alcohol intoxication		Between Onset and Death
	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.		
ted Insit Examiner	if any, leading to immediate Due to (or as a consequence of): Cuse Enter Underlying Cause (Disease or injury that initiated		
uted nd ransit	events resulting in death) Last Due to (or as a consequence of): d.		
60, tte be executed hysician and e burial - transit	XUNPENDED AMENDED 23a, PII, 27, 28a-f, per MI	E g903 5/12/10 T1	r
	13 Was decedent progrant in the	3 Ectopic pregnancy	23d. Date of delivery Month Day Year
i, P.O. E ires that the casing signed by the detached to the detached by the detached to by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying caus Cardiomegaly		obacco use contribute to the cause of death?
Division of Vital Records, P.O. Box 687, rst or Attending Physician: The law requires that the death certifica is after death. at Director: After this certificate has been signed by the attending pled in by the funeral director, page 2 should be detached for use as the artification: To Be Completed by Physician/			
fital sician: sician: is certififirector, Be (examiner? [Hospital: 4 Innation: 2 ED/Outration: 3 DOA	Other'4 Nursing Home 5	Residence 6 Other:
on of Viending Physicath. or: After this the funeral dir	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. In (Month, Day, Year)		how injury occurred
Division o spital or Attending nours after death nours after death rilled in by the fune Certification:	3 Suicide 6 Could not be determined (Specify) house	e building, etc. 28f. Location (or Town 1	Street and Number or Rural Route Number, City State) / 806 North Point Rd k, MD
To the Hospital within 24 hours To the Funeral completely fille	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opini and manner stated.	ion, death occurred at the time, date	and place, and due to the cause(s)
2	Sources Surhall, mi)	ense number C.M.E.	29d. Date signed (Month, Day, Year) May 2, 2010
	30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Stre	eet, Baltimore, MD 21201	
State Registrar	31. Date filed (Month, Day, Year) MAY 0 6 2010 32. Redistrar's Signature	-	
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DHMH 17 Rev 1/2001 OCME 2006

ESIZIO - FOXCES to I'ME (LOIGH)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 30, Day 2010 Year 11:16 рм F. John Bittner, Sr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Harford Upper Chesapeake Bel Air Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ⊈M 2 □ F Days Jul 1012 3 4, 1916 93 Hours 216-05-1857 Mary Tand Director Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits Director Rehoboth Beach 1 Yes 2X No Sussex 10e. Street and Number 10g. Citizen of What Country? Funeral 19971 USA Rd #1 Box 233 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, 4130/10 Armed Force Black, White, etc 1 Never Married 2 Married þ 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: Specify: Completed 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) President Ceramics Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Bittner Madeline 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6039 Hollins Ave., Baltimore, MD John F. Bittner, Jr.-son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hilltop Serv Corp 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 5/3/10 Towson, MD 5 Other (Specify) 4 Donation 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility 2. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd., Towson, MD 21204 Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Yes 2 ☐ No 1 Yes 2 L signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by inquinal Incarrerated 1 Yes 2 No 3 Probably 4 Unknown cate has been s ; page 2 should 24b. Were autopsy findings available prior to completion of cause of death? Dementia 24a. Was an performe After this certificate h 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 🗌 Yes 2 🗖 No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. May er of Death 28b. Time of Certificate: 28c. Injury at 5 Pending Natural 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after death

To the Funeral Director:

completed filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical quertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number D63420 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kharal MD 31. Date filed (Month, Day, Year) Registrar's Signature State barke Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Day Year Month Robert Beckey 02 2010 2:06 p 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore <u> Greater Baltimore Medical</u> Center Towson 8. Date of Birth (Month, Day, Dec 25, 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Days Min. 1**™** M 2□ F Months Hours Pennsylvania 84 122-18-1802 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h. County 1 ☐ Yes 21 No Lutherville Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21093 704 Chapelridge Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1. Yes 2 ☐ If Yes, Give Year or Dates: 1943-1 ☐ Never Married 2 Married 2 🗆 No Specify: White 1 ☐ Yes 2X No Specify: 1945 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) professor education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Samuel Alfred Beckey Mary Davis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Florence Fisher/spouse 704 Chapelridge Rd; Lutherville, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4⊠ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ronal d S. Wade 22. Name and Address of Facility State Anatomy Board; 655 W. Baltimore Street Baltimore, Maryland 21201 23a. Part 1. Enter the disease, or complications that the sed the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final ordinary CENTRO disease or condition resulting in death) Due to (or as a consequence of) as a consequence of) Due to (or as a consequence 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 1 ☐ Yes 3 Probably 4 Unknown 24a. Was an

Physician /Medical Examiner

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physician s the burial

attending pl

signed by the a

icate has been signated page 2 should b

funeral director,

filled in by the

completely

After this

24 hours after death. Funeral Director: A

within 2

Hospital or Attending

Examiner

Physician/Medical

Completed

Be

Medical Certification: To

Department of Health Important; If Item 27 any injury or other to once.

Physician

Examiner

Funeral

Director

28a-f show

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23a

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Pages 1 and 2 should be

permit.

Physician: The law requires that the death certificate be executed

P.O. Box 68760

Division of Vital Records,

Health

5-0036

2121 filed within

Maryland

Baltimoré,

72 hours

Director

Funeral

<u>Ş</u>

Completed

Be

traumatic event, the Medical Evaminer must be notified at

/Medical

10a. State

MD

Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient

autopsy

24b. Were autopsy findings available prior to completion of cause of death?

2 1 1 ☐ Yes 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

1 ☐ Yes

25. Was case referred to medical xaminer' Yes 2∐No 27. Manner of Death

5 Pending

28a. Date of Injury (Month, Day, Year) investigation 6 Could not be determined

28b. Time of Injury 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Flural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Natural

2 Accident

4 ☐ Homicide

3 Suicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 3 Day Physician/ Renee Month 5 Cheryl Carter 2010 12:05 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 2106 Harmon Avenue Balto na Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Funeral Days Min. 1 M 2 XF 215-78-6474 50 Director MD Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Exaπiner must be notified at Director 1X Yes 2 □ No MD Baltimore na 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2106 Harmon Avenue Funeral 21230 IJ S 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ☐ Yes 2**X** No Yes, Give Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: "natural" 3 Widowed 4 Divorced Specify: Black Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of Rorking life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 hand Mental Hygiene. It is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) <u>6th grade</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Josephine Aaron Carter Whitfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sister 1 and 2 s of Health item 27 i 2824 Lake Avenue Carolyn Carter Balto, Rogers 20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt Zion Cemetery 5-8-2010 20a Method of Disposition permit. Page 1 a
Department of H
Important: If ite any injury or 1 X Burial 2 Cremation 3 Removal from State Lansdown, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, 21202 MD 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ cell ducase Sichle disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) -transit Cause (Disease or linjury death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death the t 9 Unknown P.O. ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>^</u> Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has bage 2 s autopsy performed certificate 2 No 1 Yes Yes of Vital To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes ဂ္ဂ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of the funeral place on pleted filled in by the funeral completed filled f Natural 5 Pending Investigation Division 1 - Yes 2 🗌 No Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and title of cefifie 29c. License number 29d. Date signed (Month, Day, Year) D40854 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bult more 21202

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Register's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month April Physician/ 2010 Year Margaret Р Cummins 6:30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Dunda1k 505 Bayside Drive 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year) Country) Director 192 Pennsylvania 82-14-1637 Usual Residence of Decedent show 10a. State 10b. County 10d. Inside City Limits 72 hours after death with the Maryland Ħ 10c. City. Town or Location Director or 28a-f sl 1 Yes 2X1 No Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23a or edical Examiner must be Funeral 505 Bayside Drive 21222 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 TNo Specify. 3 ₩ Widowed 4 Divorced White er than "natur, 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M any injury or other traumatic event, the M gnoe. Elementary/Seconday (0-12) College (1-4 or 5+) Year <u>Baltimore Office Supply</u> 12 Years Retail Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Bernard Plunket Margaret Lonsdale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1539 Merritt Blvd. Dundalk, Maryland Margaret E. Cummins (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Sacred Ht. of Jesus Cem. 5/3/2010 Dundalk, Maryland Signature of Funeral Service License 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, shock, or hear railure. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician CEREBROUASCULAR ACCIDENT 60 DAYS disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 20 Y BAR THEROSCLEROSL Sequentially list conditions, it any, leading to immediate cause. Enter Underlying 404 FARS Exami Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed HYPERTENSION that initiated events resulting in death) Last and the burial-trar Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Dav Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ BREAS CARCINOMA 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? ARCINOMA 24a. Was an autopsy performed Yes 2 this certificate has page 2 CARDIAC 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home \$ Residence 6 Other (Specify) Hospital: 1 Tes 2 LAK မ 1 Inpatient 2 ER/Outpatient 3 DOA Manner 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred After 1 Natural 5 Pendina 2 Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by Homicide determined

State Registrar

within 2.

DHMH 17 Rev 7/2009

Medical

29a. Certifier

31. Date filed (Month,

29b. Signature and title of certified

Deepak Seth, M.D.

Up

207 Wise Ave.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Dundalk, Maryland 21222

3407

29d. Date signed (Month, Day, Year) 01

2010

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Month May **Physician** Clyde Couch 4 2010 4:15 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Harford Co. Bel Air 805 East Broadway If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months **Ж** № 2 □ F 86 400-20-4725 March 22,1924 Kentucky Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City. Town or Location 10a. State ns 23a or 28a-f show must be notified at 1 □ Yes 2 TXNo MD Harford Director Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a United States 805 East Broadway 21014 Funeral Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 natural", or 1 ☐ Yes 2 🗓 No Specify þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) United States than al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Government Civil Servant permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygie
Important: If item 27 is marked other ti
any injury or other traumatic event, the 12 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bettie Reynolds Robert Lee Couch ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bel Air, Maryland Mrs. Mildred A. Couch (Wife) 805 E. Broadway 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 5/7/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 22 Name and Address of Facility ature of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 7922 Wise Ave. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of lying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each live. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to first order cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dise to for as consequence Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an nerformed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide hours after within 24 hours af **To the Funeral D** completely filled in 1/2 Certifying Physici n: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Medical one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c License number

3+

State Registrar 31. Date filed (Month, Day, -Year)

30. Name and address of

32. registrar's Signature

32 registrar's Signature

ause of death (Item 23a) (Type, Print)

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 19h per fh 25 per doc 8903 5-6-10 yt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.

Pove Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days (Month, Day, Year) 01/21/1953 1 XM 2 □ F 57 583-60-1699 Puerto Rico **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location or 28a-f show notified at 10a State 10h Count MD Baltimore Owings Mills 1 Yes 2 XNo Director 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ó r items 23a or 8 Valleys Crest Court 21117 USA Funeral death \ 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No
If Yes, Give
Year or Dates: 1971— 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ural", or iter iled within 72 hours after 1 Never Married 2 Married Specify: Puerto Rican altimore, Maryland 21215-0036 White 1 X Yes 2 ☐ No 1971-1975 þ 3 Widowed 4 X Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Medical al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Office Manager Medical traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be fi Health and Mental H em 27 is marked ot Miriam Rosa Gregory Victor Ramon Cardona ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 78374 1008 Meadowbrook Dr., Portland, TX 78734 Miriam Gregory / Mother Important; If item 27 any injury or other tr once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🎇 Burial 2 ☐ Cremation 3 ☐ Removal from State 05/08/2010 Guanica, Puerto Rico Guanica Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility
Bailey Funeral Home and Cremation Service, PA M01452 4023 Annapolis Road, Halethorpe, MD 21227 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Ourdion Imorrar Physician /Medical Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, Examine Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events trangon The law requires that the death certificate be executed the burial-trai Due to (or as a consequence of) resulting in death) Last wlug Division of Vital Records, P.O. Box 68760, Saddle. Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy Day in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ pe 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence al or Attending Physic s after death. 2 X No 2 ER/Outpatient 3 🗌 DOA 6 Other (Specify) မ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification; 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide the Hospital within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

31. Date filed (Month; Day, Year)

I

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

lotthew

and manner stated.

weiss

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

Back

29c. License number

10-03376 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Terrence Cooper 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month 1801 hrs Medical Examiner Terrence Cooper May 2, 2010 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 3241 Eastern Avenue Baltimore If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number **Funeral** Months Days Hours Min. Director CountryMaryland 52 09/05/1957 212-52-3211 1X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 10b County 1 X Yes 2 No fother than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at once. Maryland N/A Baltimore jes 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 3241 Eastern Avenue 21224 Funeral 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married Married 2 X No Yes White If Yes, Give Year 3 Widowed 4 Divorced 1 Yes 2 No specify: Specify: \$ or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12 Security Guard Security Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arnold William Cooper, Sr. Helen Ilene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice J. Cooper - Sister 535 S. Decker Avenue Baltimore, Maryland 21224 If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Pages 1 05/07/2010 Glen Burnie, Maryland Atlantic Crematory Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Payid John Weber Funeral Homes P.A. Street Baltimore, Maryland 21231 Part I. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Combined drug (oxycodone, chlorpheniramine, **Physician** een Onset and /Medical Death a mirtazapine) intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of). Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical signed by the attending physician be detached for use as the burial -X UNPENDED 3a,27,28a-f,per EM g905 7/1/10 TT Division of Vital Records, P.O. Box 68760, IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy certificate has performe Yes Yes 2 ✔ No 2 No 25. Was case referred to medical 26.Place of Death (Check only one) To the Hospital or Attending Physician: Be Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 Other Scene this (ER/Outpatient 3 DOA 1 V Yes After t 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Natural Yes 2X No subject ingested drugs 5 Pending Director: d in by the f 24 hours after death. Funeral Director: Fd 5/2/10 unk 2 Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City cation (Street and Town, State) 3241 3 X Suicide Could not be Eastern Ave Baltimore, determined (Specify) Home Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Che one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the] 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 3, 2010 O.C.M.E. tors 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Laron Locke MD. 31. Date filed (Month, Day, Year) State Registra DHMH 17 Rev 1/2001 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Physician Mar 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 🔀 M 2 🗆 F Yrs 214-87-5216 Jan. 13, 2010 Director Marvland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 🔀 No Director the Medical Examiner must be notified Maryland Anne Arundel Millersville the 10e. Street and Number 10g. Citizen of What Country? 10f. Zip-Code or items 23a or death with Funeral 8398 Oakwood Road 21108 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after in nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married Baftimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 0 N/Acernit. Pages 1 and 2 should be filed v Legratment of Health and Mental Hygie Imp. rtant: If item 27 is marked other t any injury or other traumatic event, the orie. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lynn Allen Diffenbaucher ပ္ Lisa Marie Chandler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa M. Milligan/ Mother 8398 Oakwood Road, Millersville, Maryland 21108 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 5 Other (Specify) Metro Crematory, Inc. May 6, 2010 Baltimore, Maryland 4 Donation 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of FacilitCremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1 Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician mona disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tra resulting in death) Last Due to (or as a consequence of Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death Pregnant at time of death 3 🗌 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 2 No Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part ! 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performi Yes 2 certificate has b 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 \sum Nursing Home Yes 2 No **X**npatient 2 ER/Outpatient 3 🗌 DOA 5 Residence 6 Other (Specify) ပ this Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 4 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A completely filled in by the f 2 Accident Could not be determined 3 Suicide . Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide City or Town, State) Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Res-000 010

State Registrar

DHMH 17 Rev 1/2001

Anna 31. Date filed (Month, Day, 600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BROWN

Amend 20b, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 20b, per Fh 9903 5/6/10 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 30 A M RICHARM MAY 01 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HUSPITAL SECOURS BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 20. . . . any injury or other traumatic event, the Marter . 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Ces 2 No timore 10e. Street and Number 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 2 No þ Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life_DO NOT use retired) College (1-4or 5+) Be Father's Name (First, Middle, Last) ပ 20a. Method of Disposition **B**urial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examine the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 1 ☐ Yes 5 Other (specify) hed by the a detached 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ within 24 hours after death.

To the Funeral Director: After this certificate has been signs completely filled in by the funeral director, page 2 should be a 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of D ath 28b. Time of 28c. Injury at Work? 1 Watural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (SACTIMONE 57, words MISACHEN 31. Date filed (Month, Day, Year) 32. Registrar's Sign State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May Year Physician/ 2ัด๊10 10:15 PM James E. Dowtin. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Gilchrist Hospice <u>Towson</u> If Under 24 Hrs Hours Min. Date of Birth 9. Birthplace (State or Foreign Funeral Months Davs 1 XM 2 🗆 F YT#30/29 North Carolina 237-42-5014 **Director** 80 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland the Medical Examiner must be notified at Director 1 K Yes 2 No MD Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral items 23a USA 1819 Thomas Avenue 21216 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Black, White, etc. "natural", or þ 1 Never Married 2 Married 2 **N**O Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: B1ack Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic access." (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Petty Transfer Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Betty Dowtin Landon Dowtin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia D. Thompson / Daughter 3514 E. Baltimore, Maryland 21224 Fairmount Ave. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Loudon Park Cemetery 20a, Method of Disposition 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State 5/8/10 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22 Name and Address of Facility Loudon Park Funeral Home Wilkens Baltimore, Maryland 21229 Ave. 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line pplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final milications Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be us within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 🕅 No To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) W37W 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier f Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAVUES W

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

32. Pegistrar's Signature

			For State Registrar	State of Ma			artment of He tificate of D		nd M		giene Reg. No.	0	0	4163		
	Discovering to		1. Decedent's Name (First, Middle, La	st)						2. Date of De		_	Year	3. Time of Death		
	Physici /Medio		Gordon	Leroy	Dicker	son	, Sr.			May 2	, 201	0		10:30pм		
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			611 Woodsdale 1		- //	6 -d	Catonsvi	11e If Under 2	4 Hrs	8. Date of Bir		tim		ace (State or Foreign		
В	Funeral Director		5. Social Security Number 6. S	9x 2□F 8	e (In yrs. last birti 4	roay) rs.	Months Days	Hours	Min	July 1,	y, Year) 1925		Mary	try)		
-			212-20-0075 Usual Residence of Decedent							, ury r,	174-		riar y	Land		
	yland		10a. State 10b. County		10c. City, Town	or Lo	cation						10	Od. Inside City Limits		
	a-f al	ctor	MD Baltimon	re	Catons	vi1	.1e							1 ☐ Yes 2 🙀 No		
	or 28	Olre	10e. Street and Number				10f. Zip Code				10g. Citize	en of Wi	hat Count	try?		
	23a	rail	611 Woodsdale Rd				2122				USA					
	72 hours after death with the Maryland natural', or lieme 23a or 28a-f show diesi Exactine frout be notified at	Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Armed Forces?		13. \	Vas Decedent of His f Yes, specify Cubar	spanic Origi n, Mexican,	in? (Spe Puerto F	cify Yes or No Rican, etc.)	- 1		- America , White, e			
21215-0036	urs af	by	3 ☑ Widowed 4 ☐ Divorced	1 Tes 2 1 If Yes, Give Year or Dates:	WW II		I□Yes 2█ No	Specify:			5	Specify:	White	a		
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Maryland	o a a a	Be	17. Father's Name (First, Middle, Last William P. Dicke								Maiden S	umame	*/			
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Z	and 2 sho saith and n 27 is mu		Mary M. Homans (I				oodsdale									
<u>a</u>	s 1 and 3 f Health item 27 other tr		20a. Method of Disposition		20b. Place of	Dispo	sition (Name of natory or other place	1		ate			City or To	wn, Stete		
e E									/8/1	0	Balti	more	e. Ma	arvland		
Baltimore,	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Lice	Loudon Park Cemetery 5/8/10 Baltimore, Maryland												
	4024 d		22a Bart stautho disease or som	-liestings that assumed	the death. Do s	01.001						, MI	D 212	Approximate		
\$8.		-	23a. Port. Enter the disease, or com shock, or heart failure. List only	one cause on each li	10.			, such as c	ardiac or	respiratory a	1631,			Interval Between Onset and Death		
7	Physician /Medical		disease or condition resulting in death)	ediate Cause (Final assertion) (Michigan William (Michigan William)												
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9	ding p	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy						22	od Dato	of delive	01		
Вох	requires that the death certifica een signed by the attending pt hould be detached for use as t	Physician/M	23b. Was decedent pregnant in the past 12 months?		2 Fetal death		Ectopic pregnancy Other (specify)				23	Mon	of delive th	Day Year		
o.	that the de ned by the a detached	ıysi	1 Yes 2 No 9 Unknown	9□ Unknown												
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ita	ysiclan: Th is certificate director, pag	Be (25. Was case referred to medical examiner?					26. Place of	of Death	(Check only o						
-	di S	ဥ	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatie				4 🗀 Nurs			dence 6)		
n o	ing P	iuo i	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. T <i>y Year)</i> In	ime of iju ry	28c. Injury Work	?	1	8d. Describe I	now injury	occurre	d			
Sig	ttend death stor: /	lcat	2 Accident investigatio 3 Suicide 6 Could not b	e 29a Place of Inju	ury - At home, far	m etc		es 2□N		19f Location (Street and	Numba	r or Rum	l Route Number,		
Division of	after Direct	Certification;	4 Homicide determined	building, et	c. (Specify)	111, 3111	set, factory, office		1	City or To		74011100	, or ribra	THOUSE IVEITION,		
	To the Hospitel or Attending Ph within 24 hours alter death. To the Funerel Director: After th completely filled in by the funeral	Medicai C	(Check only 2 Medical Exal	nysician: To the best niner: On the basis of	examination and	death	occurred at the time restigation, in my op	e, date and inion, death	place, a	and due to the	cause(s) a	ind man	nner as stand	ated. the cause(s)		
	thin 2 the on the	Med	29b. Signature and title of certifier	and manner sta	1100.		29c. License	number	-		29d. Date	signed	(Month, L	Day, Year)		
	F 3 F 8		Varles Bolan	2			0	2478	3 1		may	3	, 20			
			80. Name and address of person who	completed cause of d	eath (ftem 23a)	Туре.			h a 1	1 1 A	0 0	11	00	•		
			Marks K lita	ram 1001	1 TIME H	816	INTS AV	el	711	TO. WI	UL	16	19			
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DHMH 17 Rev 1/2001

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Registrar

DHMH 17 Rev 1/2001

Mittal

31. Date filed (Month, Day,

Kraja

Spocw

Rd, Parkville

21234

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8813 Woutham
32. Registrar's Signature

ati

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- State Registrer

Certificate of Death
Reg. No.

2. Date of Death
Montb
Pay
Year

3. Time of Death

Physician /Medical Examiner

Funer Direct

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural; or items 23e or 28e-f show any injury or other traumatic event, the Madical Experiment in that the notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760, To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ıcıa dic		LINDA	1 B.	EIERN	NANN				25	04		5:05P M
nin		4a. Facility Name (I	f not institution, g				4b. City, Town, o	r Location of De	eath	4	c. County of Dea	ıth
		Chesar	oeake Ho	spice Ho	use (Ta	te)	Linth	icum			Anne Ar	ınde1
al		5. Social Security N		Sex	7. Age (In yrs.) If Under 1 Year Months Days		lin. 8. Date of Bi	rth	9 Ri	thplace (State or Foreign ountry)
or		213-40-0		1□M 2 5 F	68	Yrs.	Midital Suys	110010	Dec. 8	, 19	941 Ma	ryland
		Usuat Residence of 10a. State	Decedent 10b. County		100 Cit	ty, Town or L						10d. Inside City Limits
	'n		· ·		100. 01	ly, TOWITOIL	ocation					1 ☐ Yes 2 ☑ No
	Sct	MD		timore			Catonsv	ille				
	吉	10e. Street and Nur		:11 - D1 -			10f. Zip Code	20		10g. C	itizen of What C	•
	ra		cuart M	ills Pla			2122				U.S.	
	nue	11. Marital Status		Armed Fo		.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? an, Mexican, Pu	(Specify Yes or No lerto Rican, etc.)	D-	14. Race - Am Black, Whi	
	Ž.	3 ☐ Widowed	ed 2 Narried	1 ☐ Yes If Yes, Gi Year or D	ve		1 ☐ Yes 2√2 No	Specify:			Specify:	White
	g	0 E	15. Decedent's		Jales.	162 Door	edent's Usual Occup	ention		165	Kind of Business	/Industry
	olet		ify only highest g	rade completed)		(Give	e kind of work done DO NOT use retired	during most of v	working	100.1	Killa of Basiriess	viridustry
	Completed by Funeral Director	Elementary/Seco	ndary (0-12)	Coltege (1-4or 5+)		Secretery			Soc	ial Sec	urity Admin.
	BeC	17. Father's Name	(First, Middle, La:	st)			5002002)		Name (First, Middle			direy mamine
	To B	Gord	lon	Lee				Ţ	Fave Wol	cofe	zkv.	
		19a. Informant's Na				19b. Mail	ing Address (Street					Zip Code)
Ì		George	Eierman	n Husb	and	18 S	tuart Mil	ls Plac	e Catons	vil	le. MD	21228
	,	20a. Method of Disp	position		20b. P		osition (Name of ematory or other place		Date		ocation - City or	
			☐ Cremation 3 5 ☐ Other (Spec	Removal from	State		n Mem. Ga	1	/7/10	F	inksburg	z MD
ei l	1	21. Signature of Fu			11100		2. Name and Addre		to the same of the same of		erstown	
		Xto	alser	Mah	entin	5 F	LINE FUNE	ERAL HOM		own, MD		
		23a. Part1. Enter	ne disease, or co	mptications that	caused the deat		iter the mode of dyin				,	Approximate
		Immediate Cause (Finat	ly one cause on e	ach line.	1 a AL	CEP					tnterval Between Onset and Death
al l		disease or condition resulting in death)	n 🔏	a. Due to	(or as a conseq	- /	CEK					years
r			- 1	D40 10	(or as a conseq	derice oi).						•
	e	Sequentially list con	mediate 1	b. — Due to	(cr as a conseq	ue ica ol).						
	Ē	cause. Enter Under Cause (Disease or that initiated events	rlying injury									
	Examiner	resulting in death) L	_ast	Due to	(or as a conseq	uence of):						
	ysician/Medical			d								
	ed									- 1		
	2	IF FEMALE: 23b. Was decedent	pregnant	23c. tf yes, out	tcome of pregna		Te				23d. Date of de	livery
	100	in the past 12 1 Tyes 2		4 ☐ Pregr	nant at time of d		⊒Ectopic pregnancy ⊒ Other (specify)				Month	Day Year
	Phys.	9 🗆 Unknown		9□ Unkn	own							
	2	Part II. Other signifi	icant conditions	contributing to d	eath but not resi	ulting in the u	underlying cause giv	en in Part I.	23e. Did	tobacco	use contribute t	o the cause of death?
									1 🗆	Yes 2	2)20 No 3□P	robably 4 Dunknown
	be								24a. Was		24b. Were a	utopsy findings available
	Completed								- auto perfo	ormed? 2 2 N	death?	completion of cause of
	Be	25. Was case referr	red to medical					26. Ptace of D	Death Check only		0 12.00	
	0	1 Yes 2	No	Hospital:	Inpatient 2 🗍	ER/Outpatie	nt 3 DOA Oth	er: 4 🗆 Nursing	g Home 5 ☐ Resi	dence	6 her (Spe	ocity) TATE
	Ë	27. Manner of Death	n 5 ☐ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time o	of 28c. Injury Work	y at k?	28d. Describe	how inju	occurred	HOUSE
1	i i	2 Accident	investigati	on		1,		Yes 2 □ No				
	Ĭ	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not determine	d 286. Place	of Injury - At ho	ome, farm, st	reet, factory, office		28f. Location (City or To	Street a	nd Number or A	ural Route Number,
-	20								1			
	cai	(Crieck Drilly	1 Certifying F	hysician: To the	best of my kno	wledge, deat	th occurred at the tin	ne, date and pla	ace, and due to the	cause(s	s) and manner a	s stated.
	Medical Certification:	0.107		and man	ner stated.				Journey at the tille,			
	2	29b. Signature and	title of certifier	11	_	47	29c. Licens	e number		29d. Da	ate signed (Mon	(h. Day, Year)
		Shisa	n H.	Krieg	er, M	り	1 1144	838		05	104/	10
		3 ame and addre	ess of person who	completed ca	e of death (Item	23a) (Type.	Print)	11.	1	05		11/01

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** John Lawrence Frost, Jr. 4, May 2010 2:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 234 Chartley Drive Baltimore Reisterstown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Jan. 13,1918 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral X**(**X** M 2□ F Months 92 230-01-3963 Director Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Wedical Examination at be notified at 1 ☐ Yes XXNo Director MD Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 234 Chartley Dr. 21136 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: Specify: White 3XXVidowed 4 ☐ Divorced permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; any injury or other traumatic event, I'm Medical Exa 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Shipsfitter U.S. Coast Guard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Lawrence Frost, Sr. Clara Ellen Forbes 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Zamecki / Daughter 108 Nee1 Ave. Reisterstown, MD 21136 20b. Place of Disposition (Name of competery, crematory or other place) All Faiths 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 200 cremation 3 Removal from State Crematory & Chapel 5/5/10 | Manchester, MD 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Tome Samue Licensee 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 ☐ Pregnant at time of death □Yes 5 Other (specify) 2 □No 9 I IInknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 0 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Pruneral Director: in by the 3 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

within 2 To the

Registrar

cal

29a, Certifier

(Check only one)

29b. Signature and title of certifier

Jons 31. Date filed (Month, Day, Year) and manner stated.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

10/C

			For State	tate of Maryland / D	•		lygiene	
			Registrar		Certificate of D		Reg. No.	1.167
П	Physici		1. Decedent's Name (First, Middle, Last)		Freedon	2. Date of Month	Day Year	3. Time of Death
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	LXdiiii	ici	The Johns Hook	ins Hospita		imore City		
	Funeral	Г	5. Social Security Number 6. Sex 1	7. Age (In rs. last birth	day) If Under 1 Year Months Days	If Under 24 Hrs. 8. Date of Hours Min. (Month,	Birth 9. Bi Day, Year) 3-1915	rthplace (State or Foreign
	Director		Usual Residence of Decedent	^{2L} x ^F 94 Y	rs.	/-	3-1915	Texas
	yland 10w		10a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limits
	a-fsk	ctor	MD	na Balt:	imore			1X∏Yes 2 ☐ No
	with the	Funeral Director	10e. Street and Number 3417 Elmley Ave	nue	10f. Zip Code 212	13	10g. Citizen of What C	country?
	death	ner	11. Marital Status 12. V	Vas Decedent Ever in U.S.	13. Was Decedent of Hisp	panic Origin? (Specify Yes or , Mexican, Puerto Rican, etc.)	No- 14. Race - Am	
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mydical Evernine must be notified a once.	by	1 Never Married 2 Married	Yes 2X No Fyes, Give Year or Dates:	_	Specify:		Black
2-0	72 h	letec	15. Decedent's Educatio (Specify only highest grade cor	npleted) (Decedent's Usual Occupati Give kind of work done du	ion ring most of working	16b. Kind of Business	s/Industry unk
21215-0036	d within giene.	Completed	Elementary/Secondary (0-12) C	College (1-4or 5+)	ife. DO NOT use retired) Domestic	Worker		
nd	tal Hy d othe	Be	17. Father's Name (First, Middle, Last)	_	1	8. Mother's Name (First, Mide		
yla	ould to	ဥ	Lavelder Henders			Hattie Her		
Maryland	d2sh Ithano 27isn traun	0 1	19a. Informant's Name/Relationship (Type. F Brenda Freeman-J	ohnson 45	Mailing Address <i>(Street an</i> 540 Hazelwo	nd Number or Rural Route Nui Ood Avenue		Zip Code) 21206
ē,	f Hear frem 2	1 8	20a. Method of Disposition	20b. Place of [Disposition (Name of crematory or other place)		20c. Location - City of	
more,	Page: nent o int: If		#⊞Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	vai irom state	ison Forest	i	Owings M	ills. MD
alti	srmit. spartn spartn sports y inju		21. Signature of Funeral Service Licensee		22. Name and Address		East F/H	11107 110
<u> </u>	99 E 29		131 Clat		<u> </u>	North Avenue		
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one car	ns that caused the death. Do no use on each line.	t enter the mode of dying,	such as cardiac or respirator	/ arrest,	Approximate Interval Between Onset and Death
and or	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Carline	arrest			Moril
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ň	0 0	Physician/M	in the past 12 months?	Live birth 2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year
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<u> </u>	ysicie is cer direct	To Be	examiner? 1∠Yes 2 No Hospi	tal: 1 ☐ Inpatient 2 ☑ ER/Outp	eatient 3 DOA Other:	26. Place of Death (Check online) 4 □ Nursing Home 5 □ Re		ecify)
0	ng Ph fter th meral	Ling	27. Manner of Death 1 Natural 5 Pending	Ba. Date of Injury , 28b. Tir (Month, Day, Year) Inju			e how injury occurred	
<u>0</u>	tendii leath. tor: A the fu	catio	2 Accident investigation		M 1 □Ye	s 2 No		
DIVISION	al or At s after d al Direct ed in by	Certification:	4 Homicide determined	Be. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location City or	(Street and Number or F own, State)	Rural Route Number,
:	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, p	edical ((Check only 2 Medical Examiner:	n: To the best of my knowledge, On the basis of examination and/ and manner stated.	death occurred at the time for investigation, in my opin	e, date and place, and due to t nion, death occurred at the tim	he cause(s) and manner a ne, date and place, and du	as stated. e to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier		29c. License r	number	29d. Date signed (Mon	th, Day, Year)
			Mathe		D45	475.	May 3,	2010
	HV		30. Name and address of person who comple	() -	ype, Print)	000	. 1:	021234
	Sta	0	31. Date filed (Month, Day, Year)	32. Registrar's Signature	5 110 (100)	1611 100	I word in	1) =1 = 2[
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DHM	IH 17 Rev 1/20	001	mni v o zvi	1 Denova S.	Market			
					ORIGINAL.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Vernon George April 2010 5:40 A. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death St. Mary's Hospice House of St. Mary's Callaway Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** Months Days Hours Min (Month, Day, March 5 1 X M 2 🗆 Country) Maryland **Director** 216-16-1318 86 Usual Residence of Decedent 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f sh notified 1 Yes 2 No MD Saint Mary's Hollywood 10e. Street and Number 6 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 45017 Irvin Street 20636 United States "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Even Armed Forces? 1 ☑ Yes 2 ☐ No ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🔀 No Specify. Specify Completed 3 Widowed 4 Divorced WWII White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore other than Elementary/Seconday (0-12) College (1-4 or 5+) the Years Maintenance Worker City Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H f item 27 is marked of r other traumatic ever မ Ernest Ford Anna Ford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Bonds (Daughter) 45017 Irvin Street Hollywood, Maryland 20636 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State o = 10 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Important: I any injury o Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 4/29/2010 Baltimore, Maryland Signatur Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Dundalk, MD 21222 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause of or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No sate has been signed by the a page 2 should be detached in Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy urs after death. eral Director: After this certificate I filled in by the funeral director, pag 1 Yes 2 No Yes the Hospital or Attending Physician: 25. Was case referred to medical Hospice 26. Place of Death (Check only one) Be examiner? 2 XNo Other: House 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6X Other (Special Control of the C 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier соmpleted

<u>Jennifer Schmid</u>t, D.O.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

40900 Merchants La., Leonardtown, MD 20650

(Check

29b. Signature and title of certifier

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Year Albert Carl Grochmal 2010 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death AGNES HOSPITAI BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Nov. 29, Birthplace (State or Foreign Country) **Funeral** Days Hours 212-05-2359 **Director** 95 Maryland Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f shov event, the "historial Exemitment in the profilied at Director 1 ☐ Yes 2 ☑ No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Bull Branch Court by Funeral 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11 Marital Status Black, White, etc. 1 ∐Yes 2 Man No If Yes, Give Year or Dates: 1 Never Married 2 Married timore, Maryland 21215-0036 1 ☐Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Sales Manager Trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Wental Important: If item 27 is marked or any injury or other traumatic even once. Joseph Grochmal Pauline Fisher 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Regina Grochmal Daughter 3 Sharonwood Court; Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Cross Cemetery 5/8/2010 Brooklyn Park, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Dicesses 1630 Edmondson Avenue: Catonsville. 23a. Part 1. Enter the disc se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** RESPIRATORY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner incepitaLOPATI Saquer tially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed sician and burial-tran Due to (or as a consequence of attending physician for use as the buria Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Physician: The law requires that the death for 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ EMEN71 1 ☐ Yes 2 ☐ № 3 ☐ Probably 4 ☐ Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 No Division of Vital 1 □ Yes 1∐Yes 2**Дж**б director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 □ Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of leath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 tural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation hin 24 hours after deat the Funeral Director; 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within To the 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) ale Com une

Registrar

DHMH 17 Rev 1/2001

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Year) 31. Date filed (Month, Day,

30. Name and address

reson who complated cause of death (Item 23a) (Type, Print) Registrar's Signature

S CATON AVENUE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ HAIRSTON. 0:20AV Medical 4a. Facility Name (if not institution, give street and number) **Examiner** Town, or Location of Death 4c. County of Death 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 M 2 KF J'Corolina Director 28a-f shov iral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Xyes 2 No timore 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bace - American Indian. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 KNo Specify: "natural", 3 Widowed 4 □ Divorced permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nglay (9-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) မ 19a. Informant's Name elationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 20b. Place of Disposition (Name of cemetery, crematory or other pla 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 2 Burial 2 Germano. 4 Donation 5 Other (Specify) 21. Signatura f Fu ice Lio nsee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ SPIRATORY disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner HETHMA Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown certificate has been si irector, page 2 should I 24b. Were autopsy findings available prior to completion of cause of DISERSE 24a, Was an GROBROVASCULAR autopsy death? 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical completed filled in by the funeral director, Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 🗶 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 28b. Time of 28d. Describe how injury occurred 1 🔀 Natural 5 \square Pending injury 2 🗌 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month. Dav. Year) DO0 42680 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mo

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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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BALTIMORE WATIONAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Goldie Gwendolyn Ha11 201 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Balti ose dale If Under 1 Year | If Under 24 Hrs. 9. Birthplace *(St*ate or Foreign Country) West Virginia 7. Age (In yrs. last birthday, 5. Social Security Number Date of Birth (Month, Day, **Funeral** Yearl Months Days Hours 703-07-9622 1 □ M 2 🖺 F 1,1924 Director March 86 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Maxifical Examiner must be notified at once. 28a-f show 1 ☐Yes 2 DXNo Director Middle River Baltimore 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 12105 Buttonwood Lane United States 21220 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 XNo Specify \$ Specify: 3 XWidowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Clerical Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Michael Smith Annie Brown ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12105 Buttonwood Lane Middle River, MD 21220 Kenneth M. Hall, Jr. (Son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gdns: 5/6/2010 Middle River, MD 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or shock, or heart dilure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Firm **Physician** rneu Monio disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sis Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examine law requires that the death certificate be executed 141 ending physician and use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day signed by the a d be detached f 5 Other (specify) 1 ☐ Yes 2 No Ö 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy The perform of Vital 2 🗆 No 1 □Yes 2 X No To the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | No ၉ 1 Anpatient 2 ER/Outpatient 3 DOA After thi funeral (27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death

To the Funeral Director:
completely filled in by the i 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Franklin Fa 9000 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 14 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death tarthe 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, April 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Months Days 1 M 2 DXF Hours 220-18-8403 West Virginia Director Yrs 86 1924 Usual Residence of Decedent works or 28a-f show notified at 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Harford Bel Air 10e. Street and Number P 10f. Zip Code 10o. Citizen of What Country? ortant; If item 27 is marked other than "natural", or items 23a o injury or other traumatic event, the Medical Examiner must be Funeral 555 South Atwood Road Apt. 217 21014 United States within 72 hours after death 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 Yes 2 😾 No If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: 3XXWidowed 4 ☐ Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Amportant; If item 27 is marked other that any injury or other transmitted. Supervisor Steel Industry 12 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Nicholas Scolisky Helen Cherry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy A. Meyers (Daughter) 329 Royal Oak Drive Bel Air. MDBaltimore, 20a. Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State 1 🛣 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) 5/1/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) of Faith Cem ture of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. dalk, Marvland 21222 7922 Wise Dundalk. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition year Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): and Due to (or as a consequence of): resulting in death) Last burial-Physician/Medical certificate be Records, P.O. Box 68760 t phys as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ sate has been signed by the atte page 2 should be detached for a in the past 12 months? Day Year Pregnant at time of death Yes 2/ 9 🗌 Unknown Unknown Part II. Other significant conditions contributing to gath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 No 1 Yes Division of Vital or Attending Physician: 25. Was ca filled in by the funeral director, To Be se referred 26. Place of Death (Check only one) examiner? Hospital: Other 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work? 24 hours after death. Funeral Director: A 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. City or Town, State) Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier completed (Check To the I within 2 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 0

Date filed (Month, Day, Yea

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completed cause of death (Item 23a) (Type, Print)

rar's Signature

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V.	Physic	ian	1. Decedent's Name (First, Middle, Las					2. Date of Dea Month		2010	3. Time of Death 9:55 PM
	/Med Exami		Cordelia S. Herpi 4a. Facility Name (If not institution, give			4b City Town	or Location of Death	May	4c. County		9.JJ F
	Exami	ner	Harford Memorial				de Grace		Harf		
	Funeral	1	5. Social Security Number 6. Se	x 7. Ag	e (In yrs. last birthda	y) If Under 1 Yea	If Under 24 Hrs.	8. Date of Birth		9. Birthpl	ace (State or Foreign
0 2	Director		577-28-8241 Usual Residence of Decedent	□M 2⊠F	90 Yrs.	Months Day	s Hours Min.	Sept 11	, 1919	Mary	Tand
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10	e Ma	cto	MD Harfor	:d	Havre	de Grace					1 ☐ Yes 2X No
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-	dea	by Funeral	11. Marital Status	12. Was Decedent Armed Forces?		B. Was Decedent of	Hispanic Origin? (Sp	ecify Yes or No-		e - America	
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	Physician		Immediate Cause (Final	ne cause on each lie	ne.	4					Interval Between
	/Medical		disease or condition resulting in death)	a. Due to (or as	a consequence of):	rouch	ardiova	Olikh	v aus	easi	2
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	7 -	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or/as	a consequence of):	11001	100021	NX.			
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	Attending r death.	atic	2 Accident investigation	(Monn, Da)	, , co, , injury		Yes 2 □ No				
ERPI	l or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubulding, etc.	ury - At home, farm, : c. (Specify)	treet, factory, office		28f. Location (St City or Town	reet and Number, State)	er or Rural	Route Number,
H	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the tu	edical C	Check only 2 Medical Exami	ner: On the basis of	examination and/or	ath occurred at the nvestigation, in my	time, date and place, opinion, death occurr	and due to the cared at the time, do	ause(s) and ma	nner as sta	ted.
	thin 2 the cmple	Med	one) 29b. Signature and title of certifier	and manner sta	ited.		nse number		9d. Date signed		
	7. <u>×</u> 50	_		11.0		250. Cider	- //	/ / /	Ju. Date Signed	- /.	ay, rear
			20 Name and details	~ / VI +/			1066	1	1	>//	U
			30. Name and/address/of person who co	Cause of d	pour (item 23a) ATypi	Tion (7	- Harris	do Go	aco 1	110	21078
1	Sta	ate	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	1100171	· W-016	Ju 4/	- ()	1/	- (- ()
	Regist		MAYOR	חוחם	us A	barker					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene StateRegistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2^{Day} Physician/ April ŽÖ10 Mary Hardin 11:50 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Prince Georges Clinton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Days | Hours | Min. T. (Month, Park Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 X July 10 Fear 1937 North Carolina 217-38-8734 72 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ems 23a or 28a-f sh r must be notified a Prince Georges Clinton 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9106 Pineview Lane 20735 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ò 1 X Never Married 2 Married 1 Yes If Yes, Give 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation Unk (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) United States Elementary/Seconday (0-12) College (1-4 or 5+) Postal Service Be 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joy Ashton/friend 9115 Mar1boro Pike; Lot 9; Upp<u>er Mar1boro, MD 20772</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) In State Funeral ryice Licensee 22. State Anatomy Board; 655 W. Baltimore Street Signat Director Baltimore, Maryland 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PULMON ARY Immediate Cause (Final Ph sician/ TM BOLISM disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and To the Funeral Director, After this certificate has t een signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) 2 No 1 Yes 2 b 9 | Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ENCEPHALOPATHY 1 Yes 2 No 3 Probably 4 Wunknown HYPERTENSION 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? PNEUMONIA 1 Tyes 2 TiN 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manne of Death Certificate: 28b. Time of 28c. Injury at work? 1 🏻 Yes 2 🗖 No 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 only one) 29b. Signature a d title 29c. License number 29d. Date signed (Month, Day, Year) D0064986 4/28/ 2010 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tilha 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 30 Month 0 4 Yeart 3:06 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BAtimore City Mercy Medical 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MD **Funeral** 8. Date of Birth Days Hours Min. 215-28-3166 Yrs **Director** Usual Residence of Decedent 10b. County 10a. State within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2710 Ellicott Drive 21216 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. African-American 3 XWidowed 4 Divorced Specify Completed Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12th Claims Representative SSA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Louise Thomas William Carroll Dowery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Obrey A. Jackson/Grandson 9712 Woodyard Drive, Upper Malboro, MD 20772 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest Veterans 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. 5-10-2010 Owings Mills, MD □ Donation 5 □ Other (Specify) Signature of Funeral/Service Licenses 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** ed Mental Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit law requires that the death certificate be executed that initiated events resulting in death) Last 4MOM hs Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? lung concer Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director; After this certificate has autopsy performa Physician; The ☐ Yes 2 No 1 🗌 Yes 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) examiner? Hospital: Other: ပ 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ne Hospital or Attending Pl n 24 hours after death. e Funeral Director; After th 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 1 Natural 28d. Describe how injury occurred (Month, Day, Year) 5 Pending Accident Suicide 1 Yes 2 No Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifier 29c. License number 20067708 4/30/10 (marins mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

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31. Date filed (Month, Day, Year)

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	Funeral Director		2 6 9 1	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	9.	Birthplace (State or Foreign Country) Kentucky Kentuckey	
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	<i>(</i>)		29b. Signature and title of cell-wifer 30. Name and address of person who complete	ad cause of dee	th (Item 22s) (Time 5	29c, License	7741	. /	d. Date signed (M	20 2010	
l	Sta	e	30. Name and address of person who complet YE EEE & Hall 31. Date filed (Month, Day, Year)	ik, 1	Signature	nler l	will	lane	bel	o wo zing	
	Registra		WAY 0 6 2010	Museus	A. 160	arked					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death May 2010 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death The Johns Hopkins Hospital **Baltimore City** Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12-5-1959 5. Social Security Number Age (In yrs. last birthday) Days 1 🗆 M 💥 F 214-72-9107 MD 50 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 201 St Matthews Street 21202 USA Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify Black Specify: 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Herbert L. Wallace Trella Mae McKight 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) Trella Wallace-Mother 1400 E. Madison Street Apt 409 Balto, 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State King Memorial Pk 5-7-2010 4 ☐ Donation 5 ☐ Other (Specify) Randallstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H Balto, 1101 E. North Avenue Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final

Physician /Medical **Examiner**

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Department of Health Important: If item 27 any injury or other tr once,

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Contification

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

	disease or condition resulting in death)	aDue to (or as a consequence of):	<u></u>	arrest			,
ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): c. Numan Million Due to (or as a consequence of):	YP na	ertension unadeficier	ncy v	lirus	
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ation:	27. Manner of Death 1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	М	28c. Injury at Work? 1 Yes 2 No	28d. Describe		
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dical		sician: To the best of my knowledge, death iner: On the basis of examination and/or invented and manner stated.					
Me	29b. Signature and title of certifier,	(2	29c. License number		29d. Date	e signed (Month, Day, Year)

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2010

600 North Wolfe St, Baltimore, MD, 21287

Registrar

State

address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 2010 Philip G. Koga Mav 12:09p^M 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 212 King Johns Court Churchville Harford 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min. 1 🔀 M 2 🗆 F 551-72-5318 59 Aug. 15, 1950 California Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10h. County 1 ☐ Yes 2 ☑ No Maryland Harford Churchville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 212 King Johns Court 21028 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Yes 2 😿 If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2X No Specify. Specify Japanese American 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Scientist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Toshiyoki Tanaka Koga Sueko Sue 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Koga/ Wife 212 King Johns Court, Churchville, Maryland 21028 Lori 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. May 6, 2010 Baltimore, Maryland 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of FacilityCremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably → Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autops 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes € No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DQA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred

the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. The The Third the Control of the Attending physician and The Funeral Director: Attenthis certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit Box 68760 P.0. Division of Vital Records,

Physician /Medical

Examiner

Examine Physician/Medical þ Completed Be ٩ Certification:

Physician

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Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Oppertment of Health and Marked the Hyglene.
Important: If item 27 Is marked the than "natural", or items 23a or 28a-f show any injury or other traumatic event, fire the Modical Exprisive must be notified at

Baltimore, Maryland 21215-0036

/Medical

Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

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Medical 29b. Signature and title of certified Ashkán Bahrani, M.D.

and manner stated

Certifier (Check only | Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

602 S. Atwood Road Ste200, Bel Air, Maryland 21014 31. Date filed (Month, Day, Year)

5 Pending investigation

6 Could not be determined



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 4a,b per doc g903 5-6-10 vt.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 6:11 A^M Iris Eileen April 18 2010 /Medical 4a. Facility Name (If not institution, give street and number)
6112 8th Street 4b. City, Town, or Location of Death 4c. County of Death Examiner Chesapeake Beach Calvert Birthplace (State or Foreign Country) Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 🕅 F 226-44-8150 80 Director 09/30/1929 England Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b, County show 10a. State 10c. City, Town or Location 10d Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Exeminar must be notified at Director 1 ☐ Yes 2 🔀 No MD Calvert Chesapeake Beach 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6112 8th Street 20732 Funeral England 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🔀 No 2 Specify. Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Its IM. Elementary/Secondary (0-12) College (1-4or 5+) Beautician Beauty 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Albert Wigains Grace Pryor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Spooner / Daughter 6112 8th Street, Chesapeake Beach, MD 20732 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 04/19/2010 Hanover, Maryland 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licensee 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to (or sele consequence of) dany, teading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed burial-trar Due to (or as a consequence of) P.O. Box 68760. physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) the 9 Unknown Ś signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed peen Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy Hospital or Attending Physician: The certificate performe 2**X** No 1 □ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After thi funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Accident 5 Pending n 24 hours after death.

The Funeral Director: After the further of the further than 100 miles o 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🕏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier соmpletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2. 29b. Signature and title of ce tifier 29c. License number 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 30. Name and addr. State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Apri 7: 27 PM 30 Kinse Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death University of Mardand Medical Cent Daltimore City If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 - F Months Hours Min. (Month, Day, 214-62-9139 Director 4-6-Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore na 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1027 Cathedral Street Apt 10 C 21201 U SA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Plumming Co. Elementary/Seconday (0-12) College (1-4 or 5+) Plumber 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Cecil C. Kinsey Jean Pope 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pikesville, MD 21208 Knight Way Ann Pope -Sister 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 ☐ Burial 2x Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-3-2010 Greenmount Balto, MD Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 21202 1101 E. North Avenue Balto, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. gastric hemorrhage disease or condition resulting in death) Medical e to (or as a consequence of): Examiner years Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury for as a consequence of within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Yes 2 No 9 Unknown Unknown Part II. **Other** si**gnificant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 X No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 2 X No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year)

31

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(3) bson

31. Date filed (Month, Day, Year)

22 South Greeke St

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #26, per MD g903 5/6/10 TT
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 523 Shipley Road Linthicum Anne Arundel 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 M 2 M Days Hours Min. Sept. 5 Country)
Maryland 212-14-1913 90 Director Usual Residence of Decedent , marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits ould be filed within 72 hours after death with the Maryland Director MD 1 Tes 2 X No Anne Arundel Linthicum 10e. Street and Number 10f. Zip Code 10g. Cítizen of What Country? Funeral 523 Shipley Road 21090 USA 12. Was Decedent Ever in U.S. Armed Forces2 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White Specify: 3 Wildowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) House Wife Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Michael Backoff Florence Woodall 19a. Informant's Name/Relationship (Type, Print)

Division of Vital Records, P.O. Box 68760

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year 2010 6:50 P M Updesh S. Kapoor May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Montgomery Village
If Under 1 Year | If Under 24 Hrs. | 8. Da
Months | Days | Hours | Min. | (Mi Montgomery Village Health Care Center Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) **Funeral** 1 XM 2□ F Months Director 213-21-6776 72 9-11-1937 India Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 3 No Director Montgomery Boyds 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö or Items 23a 18504 Cornflower Road United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ģ Specify. 3 ☐ Widowed 4 ☐ Divorced natural', Asian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygien Importent: If item 27 is marked other tha any injury or other traumatic event. 12 Owner Self Empolved 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Rawail Singh Kapoor Basant Kaur 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kawalpreet S. Kapoor / Son 18504 Cornflower Road Boyds, Maryland 20841 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) Arundel Crematory 05-05-2010 Odenton, Maryland 21. Sign yur of Funeral Service Cens 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 her the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Pneumonia /Medical resulting in death) Due to (or as a consequence of): **Examiner** Clostridium difficile colitis Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Atrial fibrillation and resulting in death) Last attending physicien a for use as the burial-Due to (or as a consequence of): Box 68760, Physician/Medical <u>Cerebrovascular accident</u> IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Cher (specify) 4☐Pregnant at time of death P.O. I the a ☐Yes 2☐No 9 Unknown 9 Unknown signed by det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 90 1 Yes 2X No 3 Probably 4 ☐Unknown Anemia Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performe certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 X No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 XNo Other: 4X Nursing Home 5 Residence 6 Other (Specify) Certification: To 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death. 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a To the Hospitel Medicai 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) MD 29b. Signature and title of certifier. 29d. Date signed (Month, Day, Year) 29c. License number DL11162MD May 03, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vinu Ganti MD 10301 Georgia Ave. # 203 Silver Spring, Maryland 20902 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

Lisa Marie Knuos		1- For State Registrar		ite of Maryla	•	ertificate of		na Mei		Reg.	No. 20	10 1	418	
Physicia Medical Examir		1. Decedent's Nam Lisa Ma							Mon	of Death th D I 29, 201	ay Year	3. Time (
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Funeral Director		5. Social Security N 216-52-	0235	6. Sex	7. Age (In yrs.	last birthday) Yrs	Months Da					9. Birthplace (S Foreign Country) M		
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Baltimore, MD permit, Pages I and 2 she Department of Health and Important: If item 27 is injury or other traumani	1	20a. Method of Disp 1 X Burial 2	_	3 Removal fro	m State	Place of Dispos crematory or other	ner place)	•	Date		Oc. Location - C	City or Town, Sta	ite	
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ansit	EX	events resulting in		Due to (or as a d.	consequence o	of):								
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760, ficate be g physici	/We	IF FEMALE: 23b. Was decedent	oregnant in the	23c. If yes, o	utcome of preg	inancy					23d. Date of de		Voor	
Box 687/ death certifics he attending pl d for use as th	sician/	past 12 months	?	4 Pregna	rtn ant at time of de	onth =	al death 3 ner (Specify)	Ectop	ic pregnancy		Month	Day	Year	
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P.C ss that ss that gened be deta	[조		icant condition	ns contributing to	death but not r	esulting in the u	nderlying cause	given in P	art I. 236	_		Probably 4	_	
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of V ag Phy After thi	읽	1 Yes 27. Manner of Death	No No	28a. Date o		28b. Time of Ir		ury at Worl	k? 28d. De	scribe how	injury occurred	1		
ion frendin feath. for: /	턃	1 Natural 2 X Accident	5 Pendir	ng Eal/		Fd 10:3	30 am.¹□	Yes 2X				lication		
Hospital or Attendit 24 hours after death, 25 femeral Director: A	Certification:	3 Suicide 4 Homicide	6 Could determ	not be	of Injury - At he house	ome, farm, stree	t, factory, office	building, e	tc. 28f. Loc or T Colu	ation (Stre Town, State MD1a,	et and Number (87/2 C] (MD	or Rural Route I LOUGLEAP	Number, City	
To the Hosp within 24 hos To the Fune completely fi	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(sone) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and manner stated. 29b. Signature and title of certifier 29c. License number 2										•			
F 5 H 3	ž	29b. Signature and	title of certifier				29c. Licen	se number .M.E.			od. Date signed pril 30, 201	(Month, Day, Ye	ear)	
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O See	100	Ana Rubio N		stant Medical E	xaminer pistrar's Signatu	111 Penn S	reet, Baltim	ore, MD	21201				2	
Sta Registr	ar	31. Date filed (Mont	10620	10 Sener	a p.	Maria								

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sician and burial-trans signed by the atte Hospital or Attending Physician: 24 hours a within 2 To the

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	20c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 ☑ Unknown
		24a. Was an autopsy performed? 1 □ Yes 2 □ No
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	eath (Check only one) Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Work? Injury M 28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred
3 Suicide 6 Could not 4 Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)
	Physician: To the best of my knowledge, death occurred at the time, date and plantiminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	

824057

Ave Baltirove

29d. Date signed (Month, Day, Year)

21229

DHMH 17 Rev 1/2001

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

WODA DAMERA

LODA DAMERA INTERN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ben S. Krystyniak 3:43 AM Medical Facility Name (if not institution, give street and number) c. County of Death
Baltimore 4b. City, Town, or Location of Death **Examiner** Joseph Medical Center TOWSON If Under 1 Year If Under 24 Hrs. . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Maryland 0472471923 215-18-9113 87 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director Maryland Baltimore 1 Yes 2 X No Carney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 United States 3223 E. Joppa Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian. Armed Forces?
1 X Yes 2 Black, White, etc Completed by 1 Never Married 2 X Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates. WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Seconday (0-12) 12 College (1-4 or 5+) Tow Motor Operator Factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Walter Krystyniak Antonina Unknown and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sh ment of Health a tant: If item 27 i Joan A. Krystyniak - Wife 3223 E. Joppa Road Carney, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or other Date Saint Stanislaus

Cemetery crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 05/07/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License David J. Weber Funeral Homes P.A. 401 S. Chester Street Baltimore, Maryland 21231 Fart 1. Enter the disease, or condi-shock, or heart failure. List only on cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) neumonia Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day 4 Pregnant at time of death 2 No 1 Yes 2 L 9 Unknown q I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy perform After this certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1X Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1. Natural 5 Pending 1 🗌 Yes s after death Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check the 29b. Signature and title of certifie 101 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSIER DRIVE laba 10W: Khosrow 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Stanley Leo Kordek wonth 2010 Day 3:05 AMM May Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Timonium Baltimore Stella Maris Hospice If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Year 1927 July 16, Director 218-22-3665 82 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland N/A Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 4114 Century Rd. 21206 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married ² 1950–52 Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White 3. Widowed 4 □ Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mechanical Electrician Municipal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည August Kordek Josephine Myszkowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Kordek / Son 4114 Century Rd. Baltimore, Maryland 21206 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State St. Stanislaus Cem. Burial 2 ☐ Cremation 3 ☐ Removal from State 05/05/2010 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility David J. Weber Funeral Homes PA 401 S. Chester Street Baltimore, Maryland 21231 gnatule of Funeral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure/Listonly one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) CHRONIC OBSTRUCTIVE PULMONARY DISEASE Medical Due to (or as a consequence of) Examiner Sequentially flet conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tranthat initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 2 No completed filled in by the funeral director, page 2 should be detached g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No X Natural Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a edical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗶 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 2010 rson who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mav 2010 Fabian Thomas Liss 5:50a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8712 Bradmoor Drive Bethesda Montgomery 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month Day, Year) Michigan 1 X M 2 | F Months Days Hours Min. Director 380-18-5838 84 Jan. Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Bethesda Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20817 United States 8712 Bradmoor Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc 1 Never Married 2 Married ģ 1 X Yes 2 | No White 1 ☐ Yes 2 X No Specify: Specify 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 In and Mental Hygiene.
Is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Dept. of the Army Electronic Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Anna Teresa Phillips Bernard Liss 1 and 2 should be of Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy E. Liss/ Wife 8712 Bradmoor Drive, Bethesda, Maryland 20817 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important; If ite any injury or otl 1 Burial 2 🙀 Cremation 3 🗆 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) May 6, 2010 Baltimore, Maryland Metro Crematory, Inc. 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, 299 Frederick Road, Baltimore Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami tran Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? δ

Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed and physician a sthe burial-Division of Vital Records, P.O. Box 68760 attending phase as the the s been signed by the should be detached has e 2 page After this certificate |

72 hours after death

Baltimore, Maryland 21215-0036

1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2X No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 No 1 X Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 \(\subseteq \text{Yes} \) Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

29d. Date signed (Month, Day, Year)

Rockille, May

6,2010

9082Y

within 24 hours after death

To the Funeral Director:
completed filled in by the

after death.

31. Date filed (Month, Day, State Registrar

30. Name and address

of person who complete

 ω 1061

cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

oral Lowe	1	State of Maryland		irtment of <i>tificate of</i>		and	Mental H			20	10	1418
Physician	_	Registrar 1. Decedent's Name (First, Middle,Last)		tinoate or	Death			2. Date of De			3.	Time of Death
edical Examin	er	Coral C						Month May 2, 2				1950 hrs
30		4a. Facility Name (if not institution, give street and number) Upper Chesapeake Medical Center		4	b. City, Tow Bel air	n, or Lo	cation of Deatl	h		c. County of D Harford	eath	
Funeral	- 1		e (In yrs. Ia	ast birthday)	If Under 1	Year Days	If Under 24Hrs	_	irth (MN	A/DD/YYYY) 9	. Birthpla	ace (State or Foreign
Director		103-78-1978 1_M 2\(\textbf{X}\)F		56 Yrs.		Days	Hours Will		27,	1953	Bar	bados
any	-	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Locati	on			- 0,			100	d. Inside City Limits
*	اڃ	NJ Middlesex			Car	tere	et				1	Yes 2 X No
Maryla 28a-f	Director	10e. Street and Number			10f. Zip Co				10g. Ci	tizen of What	Country?	
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after d	현-	3 Widowed 4 Divorced or Dates:	_A No	1	Yes 2	No .	specify:			Specify:	Blac	ck
hours natur	eted t	15. Decedent's Education (Specify only highest grade con		16a. Deceden during me			n (Give kind of O NOT use ret		16b.	Kind of Busin	ess/Indu	stry
hin 72 e. than	omple	Elementary/Secondary (0-12) College (1-4 or s) +)	Child	Care	Prov	rider			Privato	e Ch	ild Care
5-0036 lied within 72 hou Hygiene. I other than "nat the Medical Exa	Ol	17. Father's Name (First, Middle, Last)						e (First, Middle				
ID 21215-00 should be filed win and Mental Hygien and Mental Hygien if it is marked other matic event, the Mental Hygien and it is marked other and it is marked other in a file Mental Event, the Mental Event its Mental Event it	B E	Unk. 19a, Informant's Name/Relationship (Type, Print)		19h Mailing	Address	(Stroot o	Lou	ise Rural Route No		Adamson		(Code)
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. It item 27 is marked other than "natural", or items 25a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	၉	Raymond K. Prescod, son			ersey	•		Salem,			State, Zip	, code)
and and fealth	-	20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from Sta		Place of Dispos crematory or oth	ition (Name			Date		Location - Ci	ty or Tow	n, State
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Baltimore, permit. Pages I an Department of He. Important: If ite injury or other tr		21. Signature of Funeral Service Licensee George	MacNa	bb 22. N	lame and Ad	idress o	Facility Cr	emation	So	ciety	of M	D, Inc.
Physician	\dashv	23a. Part I. Enter the disease, or complications that caused	the death	. Do not enter th	ne mode of o	deri dying, su	ck Koa	d Balt or respiratory a	rrest, sl	re, MD nock, or heart	A	pproximate Interval
/Medical	4	failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive Af	theroscl	erotic Cardi	ovascula	r Dise	ase				1	Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a conse										
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	Εİ	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a conscient of the conscient	equence o	f):								
6 be executed sician and burial - transit	ũ١	d	·									
e be exe	edical	UNPENDED AMENDED										
ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be r death. *etor: After this certificate has been signed by the attending physici by the funeral director, page 2 should be detached for use as the burity.	ΣI	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcor	ne of preg		tal death	3	Ectopic pregn	ancy	2	3d. Date of de Month	livery Day	Year
30x 6876 leath certificate e attending phy for use as the l	()	past 12 months? 1 Yes 2 V No 9 Unknown	time of de	-th	her (Specif)	/)						
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Records, The law require fricate has been si	ompleted	fi .		_				24a. Wa aut	s an opsy	pric	r to com	sy findings available pletion of cause of
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On Con cending sath. or: Af	틽	Natural 5 Pending	'ear)			1 Ye	s 2 No					
Division al or Attendi rs after death. al Director: # led in by the fi	ertification	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Ir	njury - At h	ome, farm, stree	et, factory, o	ffice bui	lding, etc.	28f. Location or Town		and Number	or Rural	Route Number, City
bor bor y fi	ပြ	4 Homicide determined (Specify) 29a. Certifier A Certifier Brusieles To the best of se	uden Ind	an dooth	rod at the #	me det	and place s	d due to the sa	ueo/o)	and manner =	etated	
To the Hospital within 24 hours To the Funeral completely fille	Medical	one) 2 ✓ Medical Examiner: On the basis of exa	y knowled mination a	ige, death occur and/or investigat	tion, in my o	pinion, d	leath occurred	at the time, da	use(s) i le and p	lace, and due	to the ca	ause(s)
To vit	ğ	29b. Signature and title of certifier			29c. L	icense	number		290	d. Date signed	(Month,	Day, Year)
61		(Lakelle)				D.C.M	Ε.		Ma	ay 3, 2010		
5	f	30 Name and address of person who completed cause of claren Locke MD. Assistant Medical Ex.		123a) 111 Penr	Street F	3altim	ore MD 21	201				
Sta		Laron Locke MD. Assistant Medical Ex. 31. Date filed (Month Av. York 2010) 32. Jegistra	-		exter, i		JIG, IVID Z I					
Registr	خدد	MAY ILC MILL //	4.4	M MA	CA SEA							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May Day **Physician** K Maveric 2010 03:11 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b City Town or location of Death Examiner The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Date of Birth (Month, Day, Year)
1-15-1962 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** 1 DXM 2 DF 214-78-6403 Director MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Director 1X Yes 2 ☐ No items 23a or 28a-f s rer must be notified MD na Baltimore with the I 10e. Street and Number 10g. Citizen of What Country? 10f. Zip-Code 408 E. Chase Street 21202 USA Funeral death Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 X Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: altimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2X No Specify þ Black Specify: 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12)
11th grade and Mental Hygiene. College (1-4 or 5+) Housekeeping Hilton Hotel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) injury or other traumatic event, Be Fred Lilly Louise Goodwin ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 408 E. Chase Street Balto, MD 21202 Louise Lilly-Mother item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State to Burial 2 ☐ Cremation 3 ☐ Removal from State Date Department of Important: If it any injury or o Donation 5 Other (Specify) 5-7-2010 Zion Cemetery Lansdown, MD 21. Signature of Funeral Service License 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** Du lo (or as a consequence of) disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (prisease or innur) Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or that initiated events burial-trar and resulting in death) Last Due to (or as a consequence of) physician Box 68760. Physician/Medical use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No page 2 should be detached P.O. 9 Unknown the Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been a 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has performed' 2 No 1 Yes Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No 1 Inpatient Other: 4 \sum Nursing Home 2 ER/Outpatient 3 DOA ည 5 Residence 6 Other (Specify) this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: the Funeral Director: After or Attending 5 Pending investigation Injury 1 🗌 Yes 2 □ No after death. 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ē RES COO Ma 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Khosrav 600 North Wolfe St, Baltimore, MD, 21287

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day

32. Regis 'ar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ **ESTHER** MARIE Month Day LOPOLITO • M M40 2010 0251 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Singi Hospital of Baltimore None If Under 1 Year If Under 24 Hrs. Funeral Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 1 □ M 2XXF Months Hours Min. AUG 2, 1931 166-24-4168 Pennsylvania Director 78 Usual Residence of Decedent r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🕅 XIo Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 113 Greenridge Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian þ 1 Never Married 2 XX Married 1 ☐ Yes If Yes, Give Maryland 21215-0036 1 🗆 Yes 2 🕅 No Specify: 3 Widowed 4 Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home e 1 and 2 should be filed wit of Health and Mental Hygie If item 27 is marked other in or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Farina permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Gertrude DeJohn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angelo Lucco Lopolito Husband 113 Greenridge Road Timonium, Maryland 21093 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State GreenMount Crematory May 4, 2010 | Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) nature of Funeral Saville Lin 22. Name and Address of FacMyitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ Hemorrhage and shock Due to (or as a consequence of): disease or condition 6 hark Medical resulting in death) Examiner Discerningted introvascular congulation 12 hours Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of). sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): 20045 that initiated events resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Yes 2 Co Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? Ś chronic Respiratory Failure cate has been si; page 2 should t Completed 1 ☐ Yes 2 RNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an Erd-Stage Donal Disease prior to completion of cause of death?

1 Yes 2 No autopsy performed? Yes 2 A No certificate cardiomy or thy 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔼 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? death. 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 24 hours after deal Funeral Director: Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Fune completed fi 29a. Certifier

Copulito

State

3 29b. Signature and title of certifier

Pamela Danisk

-sse MO

31. Date filed (Month, Day, Year) - - 32. Regi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009 Sinai Hospital

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

May 2, 2010

29c. License number

RES-000

Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death 11:50 AM 2010 Catherine Margaret Lewandowski MAG 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Esters Place Baltimore City N/A 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Months Days Hours Min 1 □ M 2 1 F 217-16-4543 87 Maryland May 15,1922 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No MD Baltimore Dunda1k 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3332 Wallford Drive 21222 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? 1 □Yes 2 □No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 1x No If Yes, Give Year or Dates: Specify: 3 TyWidowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 8 Years College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William T. Smith Anna M. Yent 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria J. Bradford (Daughter) 75 Woodland Drive Shrewsbury, PA 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/7/2010 Gardens of Faith Cemi Baltimore, Maryland 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Sitractive Pulmoning Immediate Cause (Final rance yerm disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inlitated events resulting in death) Last Due to (or as a consequence or) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Denertra 1 XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 AtOther (Specify) E 24KGAI 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred PLLCO 5 Pending investigation 1 2 atural Asstil Lin 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Box 68760 P.0. Records, Division of Vital Hospital or Attending Physician; 24 hours after death.

Physician

/Medical

Examiner

Funeral

Director

show

Director

Funeral

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Be

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Examiner

Physician/Medical

Completed

Be

Certification: To

Medical

4 Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier

ed other than "natural", or items 23a or 28a-f show event, the Medical Experient must be notified at

Hygiene.

and 2 should be filed w ealth and Mental Hygiel n 27 is marked other th

permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tr. once.

Physician

Examiner

/Medical

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attending phase as the

the detached ģ signed I d be det

director, page 2 should

has

this certificate

After 1

within 24 hours after death To the Funeral Director: filled in by the

physician

traumatic

72 hours after

Maryland 21215-0036

altimore,

3130

+ Kering

State Registrar

31. Date filed (Month,

🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d, Date signed (Month, Day, Year) 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wille

Easkern Au.

240

Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical UNPENDED AMENDED IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery

Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Live birth

3 Ectopic pregnancy Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a Wasan 24b. Were autopsy findings available

Time of Death

1928 hrs

10d. Inside City Limits

1 es 2 No

OVENEL

Approximate Interval

Between Onset and

Death

2 No

Foreign Country)

25. Was case referred to medical Hospital 1 Inpatient 2 🖊 ER/Outpatient 3 DOA 1 V Yes 2 No

26. Place of Death (Check only one) Other Nursing Home 5 Residence 6 Other 28c. Injury at Work? 28d. Describe how injury occurred Subject shot

autopsy

performed?

✓ Yes 2 No

28a. Date of Injury (Month, Day Year) Apr 27, 2010 1900 hrs 1 Yes 2 V No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Home

28b. Time of Injury

28f. Location (Street and Number or Rural Route Number, City or Town, State) 500 Chateau Avenue, Baltimore, Md.

death?

1 🗸 Yes

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. (Mug. April 28, 2010

Fetal death

30. Name and address of person who completed cause of death (Item 23a)

Pending

Investigation

Could not be

determined

111 Penn Street, Baltimore, MD 21201 Ana Rubio MD. Assistant Medical Examiner

State Registrar

and - transit

the attending physician are for use as the burial -

icate has been signed by the attraction page 2 should be detached for

After this certificate has

in by the

To the Funeral Director:

To the Hospital or Attending Physician; within 24 hours after death.

ģ

Completed

Be

3b. Was decedent pregnant in the

past 12 months?

27 Manner of Death

Natural

Accident

Suicide

4 V Homicide

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Monti (1) Sy 2010 III 03:32 p M George Maugans Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death N/A Baltimore 1130 Battery Avenue If Under 1 Year If Under 24 Hrs. 5. Social Security Number . Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Hours 0272271946 219-42-5682 Director MD 64 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director ral", or items 23a or 28a-f sl Examiner must be notified MD N/A Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21230 U.S.A. 1130 Battery Avenue . Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 X No If Yes, Give Page 1 and 2 should be filed within 72 hours after on nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced White Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Attorney Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Taylor W. Maugans : Jral Evelvn George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4706 Barbed Court, Hampstead, MD 21074 Janice L.Hansen, Friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🗆 Burial 2 🛚 Cremation 3 🗀 Removal from State Hillton Svc. Corp. 05/05/2010 Towson, Maryland 4 Donation 5 Other (Specify) Leonard J. Ruck, Inc. . Signature of Funeral Service Licenses 22. Name and Address of Facility 5305 Harford Road, Baltimore, MD 21214 Ugannia Sp Blo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) MYOCARDIA INFARCTION Medical Due to (or as a consequence of): Examiner CHADNIC Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or iinjury sate has been signed by the attending physician and page 2 should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Other (specify) Pregnant at time of death Yes g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy After this certificate has 2 🗌 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: ဂ္ 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of asymination and/or inventioning in the control of the cause of asymination and/or inventioning in the control of the cause of asymination and/or inventioning in the cause of asymination and/or inventioning in the cause of asymination and or inventioning in the cause of asymptotic and or inventioning in the cause of a symptotic and or inventioning in the cause of a symptotic and Medical 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMOR 301. ST MOHAMMA

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2: 50PM VIA 2010 30 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Baltimore Pikesville If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Feb 2, 1935 Birthplace (State or Foreign Country unk 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 12 F Yrs. 113-28-9650 75 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits r 28a-f show notified at 10c. City, Town or Location 10a. State 1 ☐ Yes 2 ☐ XNo Baltimore Pikesville Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number th and Mental Hygiene. 7 Is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be r USA 21208 7 W. Sudbrook Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2至 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or itel any Injury or other traumatic event, the Medical Examines any. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) office manager synagogue 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mike Stern/friend 7939 Starburst Drive; Baltimore, Maryland 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 □ Donation 5 ☑ Other (Specify) in state 21. Signature Funeral Se ²² Name and Address of Facility Board; 655 W. Baltimore Street Mirector Baltimore, Maryland 21201 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer **Physician** WOS. /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transi Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ed by the 9☐Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe 1☐ Yes 2 No the Hospital or Attending Physician: hin 24 hours after death.

the Funeral Director: After this certifical mpletely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fil Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 037573 30,2010

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

30. Name and address of person who completed

Zbull

32 Registrar's Signature park

Smith

ause of death (Item 23a) (Type, Print)

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Battime

71709

Amend Item 24a per verb., g903,05/06/2010dhb
State of Maryland Department of Health and Mental Hygiene
Amend Item 15 per fh, g903,05/06/2010dhb
Certificate of Death
Reg. No. k, Ensure All Copies Are Legible. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Year Month Physician 20PM 2010 /Medical 4c, County of Death 4b, City, Town, or Location of Death 4a. Facility Name (If not institution, give stated and number) Examiner Ho Spira 6. Sex ORTHWEST If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreig Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2 F 53 Yrs. 220-72-367 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10h County or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Himore Be Completed by Funeral Director MD 10g. Citizen of What Country? 10f. Zio Code 10e. Street and Number 21244 USA 238 3701 filed within 72 hours etter death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 ō If Yes, Give Year or Dates: Specify. Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) sisableo Disabled if of Heelth and Mental Hyg if item 27 is marked other or other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 end 2 should be Benjamin 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sister Par Kville, MD 21284 3239 Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Juins Mills permit. Page Deportment of Important: if any injury or once. Garrison 5-6 2010 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility & USA C great Funeral Services 21. Signature of Funeral Service Licensee Randallstown, MD 21/33 berty 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Kespiratory **Physician** nimediate /Medical Due to (or as a consequence of): Examiner RIGHES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Du to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): Completed by Physician/Medical sate hes been signed by the attending phys page 2 should be detached for use as the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant al time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2. No 1 Yes To the Hospital or Attending Physician: in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours after deat To the Funerei Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Old Kandallstrun, Court 32. Registrar's Sig ature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Charles Raymond Owens Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 - F Months Davs Hours Min. (Month, Day, Year) 39 Country) 218-36-8797 Director 70 Dec. MD Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s 1 Yes 2 X No Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 202 Somerset Bay Drive Apt. 102 21061 U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. ð 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No White Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Westing House/ other than Elementary/Seconday (0-12) College (1-4 or 5+) the Technician Northrop Grummam Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I permit, Page 1 and 2 should be 1 Department of Health and Ments Important: If item 27 is marked Charles Clinton Owens Eva Mae Pigott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21061Mrs Barbara A. Owens /Wife 202 Somerset Bay Drive Apt. 102 Glen Burnie, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Meadowridge Mem.Park 2010 Elkridge, MD 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Services PA 1 2nd Ave. SW Glen Burnie, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year signed by the a d be detached for 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed certificate 1 🔲 Yes Yes 25. Was case referred to medical director. Be 26. Place of Death (Check only one) 1 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 No Accident Investigation after death Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check Gertifying Nurse Practioner: To the best of my knowled all at the firm 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Darius Camerom 31. Date filed (Month, Day, Year) egistrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedents Name (First, Middle, Last) Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death George's 15447 Arbory Way Prince Laurel 5. Social Security Number 6. Sex 8. Date of Birth Feb. 27 1926 **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Months Days Hours Min. 1**X** M 2 □ F Nigeria Director Yrs 84 None Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show 10a. State 10h. County 10c. City, Town or Location 10d, Inside City Limits other traumatic event, the Medical Examiner must be notified at Director X Yes 2 □ No Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral Nigeria 20707 15447 Arbory Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. ģ 1 Never Married 2 XMarried Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Specify: Black 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Building Materials 12th æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Alfred Okolo Olopo Njokoma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20707 Catherine A. Okolo/Wife 15447 Arbory Way, Laurel, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Mary's Cemetery 5/13/2010 Laurel, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01103 313 Talbott Avenue, Laurel, MD Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shick or heart failure. List only one use on each line Immediate Cause (Final Physician/ disease or condition resulting in death) 10 Medical o (or as a consequence of) Examiner Sequentially list conditions. if any leading to immedicause. Enter Underlying Due to (or as a consequence of) Exami ending physician and use as the bunial-transit that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No O Month Day Year 5 Other (specify) Pregnant at time of death the i P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Hospital or Attending Physician: The law requires Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 2 🗌 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 1 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work's 1 🗌 Yes 2 🗀 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

10-03359 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Ty-Shawn Pitts State of Maryland /-Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day May 2, 2010 0105 hrs **Medical Examiner** x-Shawn 4a, Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Johns Hopkins Hospital **Baltimore** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State, **Funeral** Foreign Country Months Day Hours Director 16-87-6312 1 🗙 M 2 F Usual Residence of Decedent 'n 10a State 10b County 10c. City. Town or Location 1 Yes 2 No Lhimork Md Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6028 21206 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11, Marital Status 12 Was Decedent Ever in U.S. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Yes Black 4 Divorced If Yes, Give Year 1 Yes 2 No specify: 3 Widowed \$ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) of Health and Mental Hygiene.

t: If item 27 is marked other than other traumatic event, the Medical Baltimore, MD 21215-0036 17. Father's Name (First, Middle, Last 19a formant's Name/R 19b. Mailing Address (Street and Number or Rural Route Lac ber, City or Town, State, Zip Code) ationship (Type, Print) 6028 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State 20a Method of Disposition Burial 2 Cremation 3 Removal from State Donation 5 Other Specify I Service Li Part I. Enter the disease, or complication failure. List only one cause on each line Approximate Interval **Physician** Between Onset and (Medical a Complications of Cerebral Brainstem and Cerebellar Global Infarction Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical the burial -X UNPENDED #23a.ptI.II.27perME.G908.10/29/2010.WS Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death Month Day Year for use as past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Prematurity: multiple congenital abnormalities Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed Yes 2 No 1 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Hospital: 1 / Inpatient 2 Other Nursing Home 5 Residence 6 Other ER/Outpatient 3 1 V Yes 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 1 Yes 2 No 5 Pending Director: 2 ___ Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined

within 24 hours after d To the Funeral Direct completely filled in by Registrar

Laron Locke MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year) 2. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

May 2, 2010

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State

Signature and title of certifier

29b.

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

			1 - For State Registrar	State of Maryle	-	rtificate of D	Death	R	eg. No. 2	0 14201
	Physici		1. Decedent's Name (First, Middle, Las Gladys Estel				l 2 N	2. Date of Deat	2010 Yea	3. Time of Death 4:00pm M
	/Medic Examin		4a. Facility Name (If not institution, given Prince Georges Co.	e street and number) Mmunity Hospi	ital	4b. City, Town, or l Cheverly			4c. County of De	eath
	Funeral Director		5. Social Security Number 6. S 579–72–9258 1	ex ☐ M 2 Age (In y	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	B. Date of Birth (Month, Day, 03-10-1	_{Уедг)} 9. г 955 Wa	Birthplace (State or Foreign Country) Sh. DC
	laryland show	or	Usual Residence of Decedent 10a. State 10b. County DC	10c.	City, Town or Lo	ington	11			10d. Inside City Limits 1 □ Yes 🌋 No
	with the N a or 28a-	Direct	10e. Street and Number 704 51st St. NE #3	201		10f. Zip Code 20019	9	1	0g. Citizen of What	Country?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Modical Exa virtual by notified at once.	by Funeral Director	11. Marital Status 12 Never Married 2 Married 3 Widowed 4 Divorced			Was Decedent of His If Yes, specify Cuban		ify Yes or No- ican, etc.)		
3215-0036	within 72 hou lene than "natura in Medica I	Completed	Armed Forces? 1		16b. Kind of Busine. Disabled	ss/Industry				
yland	ld be filed lental Hyg ked other ic event, I	To Be C	17. Father's Name (First, Middle, Last) Charles Parker			I			Maiden Surname)	
, mary	ind 2 shou alth and N 27 Is mar er traumat	_	19a. Informant's Name/Relationship (Michelle Small/ I	Type. Print) Daughter						e, Zip Code)
pairimore	Pages 1 ament of He ant: If item ury or other		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	nemovarirum state p	liverdal	esition (Name of matory or other place, Pk Crem.	. 5–10–2	010 F	20c. Location - City Riverdale	
pair	permit. Depart Import any inj		21. Signature of Funeral Service Licen	see	10	2. Name and Address 0583 Middl	of Facility Rona eport Ln.	ld Tayl White	lor II FH Plains,M	20695
	Physician /Medical Examiner	er	23a. Part 1. Enter the disease, or compshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	b.	requencial):					Approximate Interval Between Onset and Death
0,007	tificate be executed g physician and as the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a cons						
O. DOX 0	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, Atter this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of Month	delivery Day Year
cords, r	luires that n signed b ld be deta	d by Pł	Part II. Other significant conditions of Diabetes, k	ontributing to death but not in	-		n in Part I.			e to the cause of death? Probably 4 Unknown
חבבת וו	The law rec ate has bee page 2 shou	Complete	End stage	venal c			· · · · · · · · · · · · · · · · · · ·	24a. Was ar autops perform	y prior ned? death	autopsy findings available to completion of cause of ?
1	sician; certific rector,	Be	25. Was case referred to medical examiner?	Hospital: √		Other	26. Place of Death (·	
5	g Physer this leral di	n: To	27. Manner of Death	28a. Date of Injury (Month, Day, Year	28b. Time o	N OLI DOA	4 LI Nuising Home		ence 6 Other (Sow injury occurred	pecify)
	r Attendin er death. rector; Afi by the fur	Certification	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined			M 1 □ Y	es 2□No	of. Location (St. City or Town	reet and Number or	Rural Route Number,
ַ	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		(Check only 2 Medical Exam	ysician: To the best of my liner: On the basis of exam	knowledge, deat	h occurred at the time	e, date and place, ar	nd due to the c	ause(s) and manne ate and place, and d	r as stated. due to the cause(s)
	To the within 2 To the comple	Medical	29b. Signature and title of certifier	and manner stated.		29c. License			9d. Date signed (Mo	onth, Day, Year)
•	[/		30. Name and dess of person when	My death (I	Item 23a) (Type,		000		5/1/201	O
	Sta Registra		31. Date filed (Month, Day, Year)	32. Registrar's Sig		was				
			- MMI-U-O CU	U WINDOW	/	-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day St PRICE Year CAROLYN A Month 2010 MA 11:00 AM Medical 4a. Facility Name (if not institution, give street and number)
CARROLL HOSPITAL CENTER, 200, MEMORIA Examiner 4b. City, Town, or Location of Death 4c. County of Death Westminster Avenue CARROLL 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 Maryland Funeral 1 □ M 2XXF Days Hours Min Director Yrs 220-36-2995 69 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10a. State the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Maryland Carroll Manchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "network" any injury or other transportant. Funeral United States of America 4542 Wentz Road 21102 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Was Decedent Lvc. Armed Forces? 1 Yes 2XXNo Black, White, etc. by 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify. If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4XXDivorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th <u>Deli Department</u> Weis Food Stores Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ George Jacob Mever Frances Catherine Knoll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian Alford (Friend) 4525 Wentz Road, Manchester, Marvland 21102 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1XXBurial 2 Cremation 3 Removal from State 4 Donation 5 (Other (Specify) cemetery crematory or other place) John Luther Miller Cemetery May 6, 2010 Westminster, Maryland 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 3296 Charmil Drive, Manchester, Maryland 21102 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death In rediate Cause (Final divase or condition METABOLIC ACIDOSIS Physician SEVERE Medical resulting in death) Due to (or as a consequence of): Examiner DIFFICILE COLLITES CLOSTRADIUM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 9 ☐ Unknown Month signed by the at d be detached for 1 ☐ Yes 2 ☑ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ RENAL FAILURE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be lirector, page 2 s autonsy performed? Yes 2 No 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical æ 26. Place of Death (Check only one) ဂ္ 1 Tes 2 No Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 24 hours after death. 1 ☐ Yes 2 ☐ No Investigation Could not be the Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) 29b. Signature and title of certifier CRITICAL CARE PHYSICIAN D063164 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

Kalpesh

31. Date filed (Month, Day, Year)

Patel

Avenue, Westminster

200 Memorial

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 3. Time of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death $\mathbf{May}^{\text{Month}}$ Physician/ Day010 3, 11:17P M Pacheco Gloria Ann Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie Anne Arundel Baltimore Washington Medical Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖺 F Days Hours Min 1 (M97 1777) 1 1994 5 64 Director 493-48-7859 Texas Usual Residence of Deceden 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland al Hygiene. Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 ☐ Yes 2 🏝 No Anne Arundel Odenton MD 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number USA Funeral 21113 109 Langdon Farm Circle 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian. Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ♠ Yes 2 No Specify: Mexican If Yes, Give Year or Dates Specify: Caucasian 3 Widowed 4 Divorced Completed Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natur ury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Tower Federal life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Credit Union Underwriter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Manuella Ortiz Andrew Flores 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once, 109 Langdon Farm Circle Odenton, MD 21113 David Pacheco / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arundel Crematory 05/07/2010 Odenton, Maryland 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, 1411 Annapolis Road Odenton, MD 21113
P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Arrythmia disease or condition resulting in death) Days Medical Due to (or as a consequence of): Examiner 6 Years COPD Sequentially list conditions. Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying 5 Years ng physician and as the burial-transit The law requires that the death certificate be executed Hypoxia Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physiciar 6 Years Physician/Medical Obstructive Sleep Apnea Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death detached the Unknown 9 🗌 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HTN Diabetes Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hyperlipidemia autonsy 1 Yes 2 No certificate Morbid Obesity Yes of Vital 24 hours after death.
Funeral Director: After this certificeted filled in by the funeral director, or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 🔀 No Other: 1 Yes 1 Inpatient 2 X ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 K Natural injury work?
1 Yes 2 No 5 Pendina Division Investigation 2 Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital o within 24 hours af To the Funeral Di completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

3

PASMA

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4203 32. Registrar's Signature

only one) 29b. Signature and tit

Registrar

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c, License numbe

29d. Date signed (Month, Day, Year)

DUD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# /&16b, perFH, G903, 5/11/2010, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ EDWARD RAAB Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Baltimore If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth
(Month, Day, Year)
June 1, 1957 . Age (In vrs. last birthday) **Funeral** 1 🕱 M 2 🗆 F Director - 52 Yrs 212-70-8905 Usual Residence of Decedent Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director Parkville Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country? Be Completed by Funeral United States 21234 1809 Forrest Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Race - American Indian, 11 Marital Status Armed Forces 1 X Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🔀 No Specify: 3 🗌 Widowed 4 🗌 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Operating Engineer's Construction Local #37 Elementary/Seconday (0-12) College (1-4 or 5+) Crane Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Rita M. Breen Edward Richard Raab, Sr. EDWARD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Forrest Road, Parkville, Maryland 21234 Rita M. Raab/ Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metro Crematory, Inc. May 5, 2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facilit@remation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Myo Cardia disease or condition resulting in death) Medical Due to or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Orderlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed his certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-trans that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 Yes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 1 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 1 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No s after death Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral [Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier

3. Time of Death

14:55 PM

9. Birthplace (State or Foreign

Country) Maryland

10d. Inside City Limits

Approximate Interval Between Onset and Death

Month

29d. Date signed (Month, Day, Year)

05/04/2010

1 ☐ Yes 2 🗹 No

1 Yes 2 X No

Year 20 10

(Check

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Muzulam

AZDANY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 5601 Lock Reven

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

RES 000

Blr. Baltimore, MD, 21239

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** AM VLINME)L 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Colon Punce Kehch Un tour ference Bred Rd Frunde Healt If Under 1 Year | If Under 24 Hrs. 8, Date of Birth (Month, Day) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday **Funeral** 6. Sex 1 □ M 2 F Director Raleigh, 219-16-7276 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State Examiner must be notified at Director 1 Yes 2 □ No Baltimore Md. n/a 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with to ment of Health and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or items 23a or: ury or other traumatic event, the Medical Examiner must be r. 1532 Tunlaw Road 21218 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🍎 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify Completed by Specify: 3 XWidowed 4 ☐ Divorced Black 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12)
12th grade College (1-4or 5+) Baltimore City Cook Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Winston Lula Keith 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr Barbara Rowe-daughter 1532 Tunlaw Road Baltimore, MD 21218 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Arbutus Memorial 5-6-2010 4 Donation 5 DOther (Specify) Arbutus, MD March East F/H 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Tynette 1101 E. North Avenue BALTO, MD 21202 23a. Part 1. Enter lie disease, or complications in at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be execut Box 68760. Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 1 No N 1 ∐Yes Division of Vital 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ANO 1 □ Yes Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 5 ☐ Pending investigation 1 Natural hours after death. 1 □ Yes 2 □ No 2 Accident ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a 29a. Certifier 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

reuning

filed (Month, Day, Year)

BU

32. Registrar's Signature

.21226

Colvin Ca

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 29d, per MD g903 5/6/10 TT

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Harold 7:18 C. Shipley Shipley Jr. 201 Medical 4a. Facility Name (if not institution, give street and number) 4b City, Town, or Location of Death Examiner 4c. County of Death Baltimore Balhwole If Under 1 Year If Under 24 Hrs. (8. Date of Birth (Month, Day, Year) Aug. 10, 1919 . Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 🛛 M 2 🗆 F Country) 213-16-9394 Director 90 MD Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Examiner must be notified at Director MD Baltimore 1 X Yes 2 ☐ No Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 3517 N. Rolling Road 21244 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married "natural", or ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Divorced Specify: Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical soce. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Accountant B&O Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harold C. Shipley Helen Agnes Colley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Glenn Shipley/Nephew 5943 Linthicum Lane Linthicum, MD 21090 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Mt conditive United Methodist Cemetery 20c. Location - City or Town, State Date May₀3, 4 Donation 5 Other (Specify) Randallstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 000145 Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to lor as a consequence of attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) ____ Month Vear 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death 1 Yes 2 2 9 Unknown signed by the a Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Mnknown cate has been signated by page 2 should b Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform After this certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 📈 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only on d title of cert 29b. Signature a 29c. License number 29d. Date signed (Manth, Day, Year) MO who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Bullimore 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Shipley

Jarold

22

Encus

Physician/ Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed

Baltimore, Maryland 21215-0036

Completed by To Be Medical Certificate:

Division of Vital Records, P.O. Box 68760

	disease or condition resulting in death)	a CORDIVIARY ARIEKY DISONSE		
	1	Due to (or as a consequence of):		
)	Sequentially list conditions, if any loading to immediate cause. Enter Underlying Cause (Disease or iinjury	b. — Dust to (or as a nonsequence of:		
-	that initiated events resulting in death) Last	Due to (or as a consequence of):		
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	23d. Date of de Month	elivery Day Year
		contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to	
			autopsy prior to performed? death?	topsy findings available completion of cause of
}	25. Was case referred to medical examiner?	26. Place of Death (Check onl	ly one)	
	1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	5 Residence 6 Other (Spec	cify)
	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident Investigatio 3 ☐ Suicide 6 ☐ Could not I	injury work? M 1 ☐ Yes 2 ☐ No	. Describe how injury occurred	
	4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Location (Street and Number or Ru City or Town, State)	
	(Check 2 L Medical Exam	vsician: To the best of my knowledge, death occured at the time, date and place, and du inner: On the basis of examination and/or investigation, in my opinion, death occurred at the time Practioner: To the best of my knowledge death occurred at the time, date and place are	time, date and place, and due to the	cause(s) and manner state

121336

29d. Date signed (Month, Day, Year)

5/4/10

PASADENA, MD 21/22

Registrar DHMH 17 Rev 7/2009

State

within 24 hou

To the Fune

completed fil

29b. Signature and title of certific

31. Date filed (Month, Day,

0.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

POZE RIJENIE

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Pleas						elible Inl			•		,	gible.		
		for State Registrar		Sia	ate of iv	iai yiai i		•	ficate of L			vientai n	Reg. I	0.0	10	142	07
Physici	an/	1. Decedent's Name	e (First, Middle,	,) i ab a w	- T7		C+ o				2. Date of D Month	eath	Day	Year	3. Time of	
Med Exami	ical	4a. Facility Name (if	not institution, g		Richar nd number)	a ver	non		b. City, Town, or	r Locatio	n of Death	April	$\overline{}$, 201 4c. Count		8:14	4 P ^M
Exam	IIGI	Holy Cro			,			- 1	Silver						gome		
Funera Director		5. Social Security No. 201-18-4		5. Sex 1 🔀 M 2		ge (In yrs. la	as <i>t birthd</i> Yr:	M	f Under 1 Year lonths Days	If Unc	der 24 Hrs. Min.	8. Date of B (Month, D Sept	irth ay Yea	7 0 2 0	9. Birtl	nplace (State of intry) 1Sylvan	r Foreign
		Usual Residence of	Decedent			81		<u> </u>		1		Sept	LZ,	1926	Pem	isyivan	1a
ryland -f sho ied at	Director	10a. State	10b. County				y, Town o	r Locati	on							10d. Inside Cit	
he Ma or 28a notif	Dire	MD 10e. Street and Num	Prince	e Geor	rge	Lau	ırel		10f. Zip Code				10a	Citizen of	What Cou	1 \(\text{Yes} \)	2 💥 No
with t s 23a ust be	Funeral	16207 La	aurel R	idge I	rive				20707				_	.S.A.		,	
death items ner m	Fu	11. Marital Status		Arr	s Decedent ned Forces?	?	6.	13. Was	Decedent of H	lispanic (an, Mexic	Origin? (Spo	ecify Yes or No Rican, etc.))-		ce - Amer	ican Indian,	
s after al", or Exami	d by	1 ☐ Never Marri 3 ☐ Widowed		If Y	XYes 2 ☐ ′es, Give arorDates.	No			Yes 2 X No					Specify			
hours "natur dical I	Completed	(Spe	15. Decedent	's Education	1				t's Usual Occup		ast of work	ina		6b. Kind of Business Industry			
thin 7%	No.	Elementary/Seco			lege (1-4 or 4	5+)	life	e. DO N	IOT use retired)	aumg m	OSL OF WORK	nig .	United States Government			tes	
iled will Hygid other	Be (17. Father's Name (F	First, Middle, La	st)			Accountant Gover 18. Mother's Name (First, Middle, Maiden Surna										
ld be f Menta arked atic ev	<u>ا</u> د	Carl Ste	evick							Zen	obia	Eshlem	an				
shou h and 7 is m traum		19a. Informant's Na					1	_	Address (Street a								
Healt Healt tem 2		Margaret 20a. Method of Disp	position		 	20b. P	_		Laurel	Rid		Date	T		-	d 20707 Town, State	,
Page 1 nent of nnt: If i		1 🖾 Burial 2 [4 ☐ Donation	☐ Cremation 3 5 ☐ Other (Sp	B ☐ Remov ecify)	al from State	e C	emetery,	cremato	ory or other place Cemete:	,			1				
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fur	neral Service Lic	ensee //	/			22 N	ame and Addres	ee of Fac	sility						
<u> </u>		Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389 23a. Part 1. Enter the rise ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart forms. List only one cause on each line. Approximate Interval Between															
hysician		shock, or heaf Immediate Cause (I	ft falure. List on Final	ly one cause	e on each lir	ie.	i. Do not	Citter ti	ie mode or dym	ig, sucir	as caldiac	or respiratory a	111631,			Interval Bety Onset and D	ween
Medica	1	disease or condition resulting in death)	n 🔏	_ a	Sepsis	a consequ	ence of):										
Examinei		Sequentially list conditions, b. Respiratory Failure															
red	Examiner	Due to (or as a consequence of): Cause Enter Underthing Cause (Disease or injury)															
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n certificate be tending physici r use as the bu	n/M	IF FEMALE: 23b. Was decedent	pregnant		es, outcome									23d Da	ate of deli	verv	
requires that the death certificate by been signed by the attending physic should be detached for use as the b	sicia	in the past 12 n	months?	4 [Live Birth Pregnant Unknown				ctopic pregnanc ther (specify)	СУ					onth		'ear
es mar me signed by th	Phy	9 Unknown Part II. Other signifi	icant condition			but not res	ulting in t	he unde	erlying cause giv	ven in Pa	ırt I.	23e. Did	tobacc	o use cont	tribute to	the cause of de	eath?
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iw requass been 2 shou	plete											24a. Was	s an opsy			opsy findings a ompletion of ca	
n: The law ficate has or, page 2 s	Com											perl 1 🗆 Yes	formed:	? No	death?	2 🗆 No	
sician certifi irector) Be	25. Was case referre examiner? 1 \sum Yes 2 \boxed{X}	ed to medical	Hospital	: , r X , ,					er:	eath (Chec						
ig rny ter this neral d	te: To	27. Manner of Death	r		Date of injustion (Month, De	ury	28b. Tim inju	ie of	28c. Injury	y at	Nursing Ho	ome 5 🗌 Res 28d. Describe				<u>(y)</u>	
tendir leath. lor: Af the ful	Certificate:	2 Accident 3 Suicide	5 ☐ Pending Investiga 6 ☐ Could no	tion		, ,				Yes 2	□No						
after of Direct	Cert	4 Homicide	determin		. Place of In building, et	jury - At ho tc. (Specify)	me, farm,	, street,	factory, office			28f. Location City or To			er or Rura	al Route Numbe	er,
to the hospital of Attending Physician; The law within 24 hours after death. To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2:	Medical	29a. Certifier 1 (Check 2	Certifying F	hysician: T	o the best o	f my knowl	edge, dea	ath occu	ured at the time	, date an	d place, ar	d due to the c	ause(s)	and mann	er as stat	red.	aner stated
thin 24 the F mplet	Me		☐ Certifying N							e time, d	ate and plac		he caus	e(s) and m	anner as s	stated.	illei Stateu.
5 5 8 8		> A	1/20(Val	6			D681					7 3,		Day, Year)	
HI,		30. Name and addre	ess of person wi	no complete	ed cause of	death (Item	23a) (Typ	oe, Print				i		<i>J</i> ,			
V		Dr. Neji		1	500 F			n Ro	oad, Sil	lver	Spri	ng, Mai	ryla	and 2	0910		
Sta Regist		L. Laissa (Month	MAYAA	วกงก	J. I gisu	a o oigilat	B	R	001								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Spence ncent 135PM Mai Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner university of Manyland Mechical conter Baltmore If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Months Hours Min. (Month, Day, Year) Feb. 5.1949 Country) Pennsylvania 219-52-4931 Director 61 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a ar 200 con any injury or other traumatic access. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Baltimore Catonsville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1204 Brandford Road 21228 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married X Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Automotive Service Director Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John C. Spence, Jr. Catherine Doyle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Matthew Spence 1994 Branford Road; Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cem. 5/7/2010 Baltimore, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Tuneral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service I censes MODO SU Avenue; 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician, disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or impury that initiated events Examine Due to (or as a consequence of) attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe Yes 2 death? 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached

Accident 3 Suicide

Investigation Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

21201

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5. Greene Baltimore,

31. Date filed (Month, Day, Year) MAY 0

State Registrar

Medical

29a. Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 8:52 P M April 30, 2010 Margaret M. Schneider /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 6504 Woodbridge Circle Catonsville Baltimore 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 ☐ M 2 🔀 F 212-34-7019 Director 73 Sept. 18, 1936 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f st any injury or other traumatic event, Ite Medical Evaning must be rectified. Director 1 ☐ Yes 2 € No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6504 Woodbridge Circle 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George T. Kohler Louise Norris ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul J. Schneider Husband 6504 Woodbridge Circle; Catonsville, MD 21228 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Atlantic Crematory Glen Burnie, MD 5/3/2010 4 □ Donation 5 □ Other (Specify) 21. Sign thre of pureral Service Lic pace 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Adenocarcinoma of unknown **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): 6 months Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Year Day 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate 1 ☐ Yes 2 No 2 No 1 ☐ Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1∐Yes 2⊠No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No 124 hours after death.

In Funeral Director: A pletely filled in by the funeral place. investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State Registrar DHMH 17 Rev 1/2001

Medical

completely

within 2 To the I

29a. Certifier

(Check only

31. Date filed (Month, Day, Year,

29b. Signature and title of certifier

MIRNI

7141 Security ▶2. Registrar's Signature

and manner stated

KHALID, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KHALID

† Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

69300

29d. Date signed (Month, Day, Year)

Baltimore, MD 21246

May, 03,2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			101	epartment of Health and N	Mental Hyg	iene	
			The ground is	Certificate of Death	Re	eg. No. 2	16210
	Physicia		1. Decedent's Name (First, Middle, Last) Steve w Stavrakis	Sr.	2. Date of Death Month May 2	Day Year	3. Time of Death 1:35P M
	Medic Examin		4a. Facility Name (if not institution, give street and number) 719 Oldham Street	4b. City, Town, or Location of Death Baltimore Ci		4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birtho	Months Days Hours Min	8. Date of Birth	9. Birt	hplace (State or Foreign intry) WV
	d d	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of	at analog			
	larylan 3a-f sh lified a	Director		nore City			10d. Inside City Limits 1 Yes 2 □ No
	n the N a or 20 be not	al Dir	10e. Street and Number	10f. Zip Code		0g. Citizen of What Co	untry?
	ath wit ems 23 must	Funeral	719 Oldham Street 11. Marital Status 12. Was Decedent Ever in U.S.	21224 13. Was Decedent of Hispanic Origin? (Spe		JSA 14. Race - Amer	ioon Indian
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fi	1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced Armed Forces? 1 □ Yes 2 □ XNo If Yes, Give Year or Dates.	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:		Black, White	
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212	within jiene. er thar the N		Elementary/Seconday (U-12) College (1-4 or 5+)	fe. DO NOT use retired) Diesel Mechanic		Trucking	ī
Maryland 21215-0036	12 should be filed valth and Mental Hyg 27 is marked other r traumatic event,	To Be	17. Father's Name (First, Middle, Last) Kyrmenis Stavrakis	18. Mother's Nam Goldie		aiden Surname)	
, Mary	id 2 should salth and N n 27 is ma er trauma			Mailing Address (Street and Number or Rura 9 Oldham Street,			
altimore,	Page 1 and ment of Heal ant: If item 2 ury or other		1 XP wint 2 Compation 2 Demoval from State Cemetery.	oisposition (Name of crematory or other place) awn Cemetery 5-5-		20c.Location - City or Baltimore	
Balt	permit. Departn Importa any inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Bra	_		eral Home
			23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between
Ġ	Pnysician/ Medical		Immediate Cause (Final disease or condition resulting in death) a. MFTATATIC Due to (or as a consequence of):	VON-Small Cell 1	ung Cr	PRICER	Onset and Death
	Examiner	_	Sequentially list conditions, b.		U		
	ed nsit	Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	ate be executed physician and the burial-transit	I Exa	that initiated events resulting in death) Last				
200	physic the bu	edical	d				
Box 687	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deli Month	very Day Year
o		Phys	g □ Unknown	the conduction control to the Control	1		
ds, P.	quires tha en signed ould be de	ted by	Part II. Other significant conditions contributing to death but not resulting in t	ne underlying cause given in Part I.		acco use contribute to	the cause of death?
Division of Vital Records,	sician: The law requires that the certificate has been signed by the rector, page 2 should be detach	Completed by			24a. Was an autopsy perform 1 \(\sum \) Yes 2	24b. Were autoprior to codeath?	opsy findings available ompletion of cause of
<u>ta</u>		Be	25. Was case referred to medical examiner?	26. Place of Death (Check			
<u>o</u>	I or Attending Physician: after death. Director: After this certific in by the funeral director,	e: To	1 ☐ Inpatient 2 ☐ ER/Outp 27. Magner of Death 28a. Date of injury 28b. Tim	ne of 28c. Injury at	me 5 KResider 28d. Describe hov	nce 6 Other (Special of the Communication of the Co	fy)
lo O	tending eath. or: Aftu	Certificate:	1 Natural 5 Pending (Month, Day, Year) inju 2 Accident Investigation 3 Suicide 6 Could not be	work? M 1 □ Yes 2 □ No			
DIVIS	ital or Att irs after d al Direct led in by		4 ☐ Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Stre City or Town,	eet and Number or Run State)	al Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or in only one) 3 Certifying Nurse Practioner: To the basis of my knowledded.	nvestigation, in my opinion, death occurred at lge, death occurred at the time, date and place	the time, date and	place, and due to the c	ause(s) and manner stated.
	To with		29b. Signature and title of certifier Mulwey Aueulaach m2	29c. License number D33551	29	NA43, 2	Day, Year)
		Ì	30. Name and address of person who completed cause of death (Item 23a) (Typ. Michael Auerback 9110. Philadelphi	De, Print) 1, Ro #314, BRI	4, more	mD 2	1237
	Stat Registra		31. Date filed (Month, Day, Year) NAY 0 6 2010 32. Registrar's Signature	park			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MAY 04 2010 **SMULYAN** 6:25 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1055 WEST JOPPA ROAD, #350 BALTIMORE TOWSON 5. Social Security Number Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 **X** F Months Davs Hours 91 0272871919 199-09-1918 MD Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c, City, Town or Location 1 Yes 2 No TOWSON BALTIMORE 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21204 USA 1055 WEST JOPPA ROAD, #350 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. WHITE 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed)

PSYCHOLOGY

20c. Location - City or Town, State

TOWSON, MD

ABRAMS

18. Mother's Name (First, Middle, Maiden Surname)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3518 BARTON OAKS ROAD, BALTIMORE, MD 21208

Date

5/6/2010

21204

ANGELA

THERAPIST

HILLTOP SERVICE CORP

20b. Place of Disposition (Name of

Physician/ Medical Examiner

Physician/

Medical

Examiner

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

SELMA

10a. State

MD

Elementary/Seconday (0-12)

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type, Print)

20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

WILLIAM SMULYAN/SON

4 Donation 5 Other (Specify) 21. Sign ture of Funeral Service Ligense

ALEXANDER

College (1-4 or 5+)

BRASH

Director

Funeral

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Completed

Be

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To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trans

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Physician/Medical Examiner Completed by within 24 hours after death. To the Funeral Director: After this certificate has Be Medical Certificate: To

21. Sign ture of Funeral Service Ligense	22. Nan 890	ne and Address of Facility S	OL LEVINSO ROAD, PIK	N & BROS ESVILLE,	., INC. MD 21208
shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to manufacture cause. Enter Underlying	2	mode of dying, such as cardiac	or respiratory arrest,		Approximate interval Between Onset and Death
Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 → No 9 ☐ Unknown		opic pregnancy er (specify)		23d. Date of de Month	livery Day Year
Part II. Other significant conditions con	tributing to death but not resulting in the underly	ying cause given in Part I.		_	the cause of death?
			24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of s 2 🂢 No
25. Was case referred to medical examiner?		26. Place of Death (Check	k only one)		
1 🗆 Yes 2 💢 No	ospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐	DOA Other:	ome 5 Kesidence	6 ☐ Other (Spec	ifv)
27. Manner of Death 1 Manual 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury M	28c. Injury at work?	28d. Describe how inju		
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	ctory, office	28f. Location (Street a City or Town, Stat		ral Route Number,
(Check 2 Medical Examine	cian: To the best of my knowledge, death occure er: On the basis of examination and/or investigatio Practioner: To the best of my knowledge, death	n, in my opinion, death occurred a	t the time, date and place	e, and due to the	cause(s) and manner stated.
29b. Signature and title of certifier		29c. License number	29d. D	ate signed (Month	n, Day, Year)
Mari Set.	CENP	R149194	m	ay 4, 20	010

State Registrar Tousen

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Revistrar's Signature

31. Date filed (Month, Day, Year)

	-	_		
10		13.	15	A .

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Tawana Sherea Syfrett State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death											
		1- For State Registrar 1. Decedent's Name (First, Middle,L	not)	Certifica	ate of Dea	ath 		Reg 2. Date of Death	. No. 4 U I U	3. Time of Death	
Physici Medical Exami		Tawana Sherea S	Syfrett					Month [April 23, 20		1440 hrs	
		 Facility Name (if not institution, 13703 Flint Rock Road 	give street and number)			, Town, or Locati ckville	on of Death		4c. County of Death Montgomery	1	
Funeral		5. Social Security Numberunk 6.		In yrs. last birth			Inder 24Hrs.	4	Foreig	thplace (State or UNK	
Director		Usual Residence of Decedent	M 2XF	38	Yrs.	luis Days Ho	Jurs Iviiii.	Sept 15	, 1971 co	untry)	
v any	ı	10a. State 10b. County	10	c. City, Town o			· · · · · · · · · · · · · · · · · · ·			10d. Inside City Limits	
Aaryland 28a-f show 1 at once.	ģ	MD Montgo	omery	Rockv		Zip Code		1400	. Citizen of What Cour	1 Yes 2 X No	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Director	13703 Flint Ro	ock Road			20853		109	USA	iuy:	
th with	Funeral	11. Marital Status UIIk 1 Never Married 2 Married	12. Was Decedent Ev	er in U.S. N.K		dent of Hispanic ocify Cuban, Mexic			14. Race - Ameri White, etc.	can Indian, Black,	
fter dea	y Fur		1 Yes 2 led If Yes, Give Year	No	1 Yes	2 X No spec	cify:		Specify: bla	ck	
hours a natura Examir	ed by	15. Decedent's Education (Specify				al Occupation (Gi			6b. Kind of Business/I	ndustry UNK	
D36 thin 72 ne. • than " [edical]	Completed	Elementary/Secondary (0-12) unk	College (1-4 or 5+) unk								
15-0C filed wi Hygier d other		17. Father's Name (First, Middle, La	st) unk			18.Mot	ther's Name (First, Middle, Ma	iden Surname)unk		
212' uld be i Mental marke	To Be	19a. Informant's Name/Relationship	(Type, Print)	19b.	. Mailing Addre	ss (Street and N	Number or Ru	ural Route Numbe	er, City or Town, State	, Zip Code)	
MD nd 2 sho alth and m 27 is		0.C.M.E.		Ton D					Maryland 2		
IOFE, uges 1 au nt of He t: If ite		20a. Method of Disposition 1 Burial 2 Cremation			r Disposition (N ory or other place	lame of cemetery, ce)	'	Date	20c. Location - City or	Town, State	
altin mit. Pa partmet portan ury or	ŀ	4 Donation 5 X Other Spec 21. Sign ture of Fun ral Service Lic 2 na 1 d S	egseg	tor	22. Name ar	nd Address of Fac	cility Book	· 4 · 655 1	W. Baltimo	ro Stroot	
		23a, Part I. Enter the disease, or con			Balt	imore, M	arylar	d 21201	w. Daltillo	Approximate Interval	
Physician /Medical	Ì	failure. List only one cause on	each line. a. Cardiac ari							Between Onset and Death	
Examiner		or condition resulting in death)	Due to (or as a consequ	ence of): of	papill	Lary mus	cle	OMGIGGS	21130202011		
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequ	ence of):							
d	Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequ	ence of):							
executed ian and ial - transit		X UNPENDED	dAMENDED			44.0.44.0. ==					
~ o .g.c.	/Med	IF FEMALE:	23c. If yes, outcome		G904 6/	/18/10 T			23d. Date of delivery		
	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at tim	e of death 5	Fetal deat		opic pregnan	су	Month D	day Year	
B ₹ g m	Phys	1 Yes 2 No 9 V Unkno	9 Ulikilowii	it not regulting	in the undertwi	na causa diyan in	Port I	23e Did toba	acco use contribute to	the cause of death?	
Records, P.O. Box The law requires that the death icate has been signed by the atte page 2 should be detached for u	Ď		contributing to death be	at not resulting	in the underlying	ng cadac given in	i i dici.		2 No 3 Prob		
cords, law requirents has been a	Completed					·		24a. Was an autopsy		topsy findings available ompletion of cause of	
tal Reccision: The la certificate ha ector, page 2	Som						_	performe 1 ✓ Yes 2	ed? death? No 1 ✓ Ye	s 2 No	
Vital hysician: this certiful director.	o Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient	2 ER/Out	tpatient 3	26 Place of Dea			esidence 6 🗸 Other	: Scene	
ling P	⊢ŀ	1 Yes 2 No 27. Manner of Death 1 X Natural 5 Reading	28a. Date of Injury (Month, Day,Year)		ime of Injury	28c. Injury at W	/ork? 2	28d. Describe hov			
ision Attender death	icati	2 Accident Investig	ation 28e Place of Injury	- At home, far	m, street, facto	1 Yes 2 ry, office building		28f. Location (Stre	eet and Number or Ru	ral Route Number, City	
Divisior Bospital or Attent 24 hours after death Funeral Director: tely filled in by the	Certification:	3 Suicide 6 Could n 4 Homicide determin	ot be	·				or Town, Stat			
To the Hos within 24 h To the Fun	Medical	Concon only	ician: To the best of my kr er:On the basis of examin	_							
To To Con	Me	29b. Signature and title of certifier	and manner stated.		2	9c. License numb	oer	2	9d. Date signed (Mor	oth, Day, Year)	
		high,	no	h //h 00 '		O.C.M.E.			April 24, 2010		
		 Name and address of person wh Ling Li, MD Assistant 	o completed cause of deat Medical Examiner	-	Street, Bal	timore, MD 2	1201				
St Regist	5.55	31. Date filed (Month, Day, Year)	32 Registrar's	Signature	back						

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

JOSE TOMOREZ

10-03428 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

UNK UNK		1- For State	tate of M	laryland					d Men	tal Hy	giene	5	0.0.1	0	1.00
Di		Registrar 1. Decedent's Name (First, Mid	dlo Lact)		Ce.	піпса	te of D	eatn				eg. No.	<u> </u>	U H	461
Physicia Medical Examir			NUEL	Too	nno					j	2. Date of Deal	Day	Year	3. Time of 1839	
		4a. Facility Name (if not institut	on, give street	and number)	MAR	E 2	4b. (City, Town, or I	Location o	of Death	May 3, 20		ounty of De		1113
- media		2936 Greenmount A	/enue	- /			i	altimore		J. 20047			ou.n, o. 20		
Funeral		5. Social Security Number	6. Sex	7. Ag	e (In yrs. I	ast birtho	day) If	Under 1 Year	If Unde	er 24Hrs.	8. Date of Bir	th (MM/DD	/ YYYY) g. l	Birthplace (Sta	ate or Foreign
Director	ĺ	119-86-5850	1 M 2	F	4	15	Yrs.	Months Days	Hours	Min.				Country)	
	ŀ	Usual Residence of Decedent			/						NOV	6/9	64 D	OMINICH	IN KEP.
any		10a. State 10b. County			10c. City,	Town or	Location							10d. Insid	e City Limits
and show	٦	NY	VY		N	Y								1 Ye	s 2 No
daryla 28a-f	Director	10e. Street and Number					10	f. Zip Code			10	g. Citizen	of What Co	ountry?	
vith the Maryland s 23a or 28a-f show s e.notified at once,	ᄚ	546 ISHAI	STR	REET				1003	34			1	15		
Imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status	12. W	as Decedent med Forces?		.S. í	13. Was De	cedent of Hisp	panic Orig	in? (Spe	cify Yes or No-	14.		erican Indian,	Black,
deatl or ite	티.	1 Never Married 2 N	1	Yes 2	No No			pecify Cuban,			,		White, etc.		
s after ral",	٦		vorced If Yes, C or Date	s:			1 Yes	2 No	specify:	Don	NINICAL	Sp	ecify: B	ALK	
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-00 I with ther t	팅	17. Father's Name (First, Middle	l aet\			V	ELD		O Mothori	a Nama /	First, Middle, M			CTION	
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21215-0036 and be filed within 7 Mental Hygiene. marked other than	<u>"</u>	AMBROCIO 19a. Informant's Name/Relation	ship (Type, Pri	<i> Y </i>	_	19b. i	Mailing Add	tress (Street	and Num	ber or Ru	ral Route Num	her City o	r Town Sta	ote Zin Code)	
AD 2 sho h and 27 is	-	Λ	E JES	-		30	20 E	AST Z	39 Th	STRA	FF-T	NY	NV 1	Ochi (. 10 A
Baltimore, MD permit. Pages I and 2 she Department of Health and Important: If item 27 is injury or other traumarinjury.	t	20a. Method of Disposition	_	-	20b. F	Place of [Disposition	(Name of cem	etery,	0 / / - (Date ,	20c. Loca	ation - City	or Town, State	3
nor of nt of nt: If other	-	1 Burial 2 Crematio		noval from Sta	te C	crematory	or other p	lace)				()	50		
nit. Partine artine ortan	ŀ	4 Donation 5 Other S 21. Signature of Funeral Service	pecify: Licensee		CL	LAR	22. Name	and Address	of Facility	MAY	(3 20;0	JANT	O Dom	NGO L).R-
Balt permit Depart Impor injury	1	21. Signature of Funeral Service 22. Signature of Funeral Service 23. Part I. Enter the disease, or failure List only one cause	Carl	ton C.	Dou	glas	P	ERA E	-	1/		2109	5 T A 1 .	1	NYNY
Physician	7	23a. Part I. Enter the disease, or	complications	that caused	the death.	Do not e	enter the mo	ode of dying, s	uch as ca	rdiac or r	espiratory arre	st, shock,	or heart	Approxim	1 003
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cast certificate beath certificate trattending physical for use as the bu	M 2	F FEMALE: 3b. Was decedent pregnant in t	23c. l	f yes, outcom	e of pregn	nancy			_			23d. Da	te of delive	ry	
certification ce	clar	past 12 months?	'	Live birth Pregnant at t	ime of dea	2 L ath 5	Fetal de	_	Ectopic	pregnand	Ey .	Mor	nth	Day	Year
Box 6876. e death certificate the attending phy ed for use as the t	Pnysician/M	1 Yes 2 No 9 Un	`=	Unknown		3 [Other (Specify)							
that the d		Part II. Other significant condit	ions contribu	iting to death	but not re	sulting in	the underl	ying cause giv	en in Par	t I.	23e. Did tob	acco use	contribute to	o the cause of	death?
	o o	Carbon mono	xoide e	xposur	:e						1 Yes	2 No	3 Pro	obably 4 🗸	Unknown
Records, The law requir ficate has been s, page 2 should 8	Completed										24a. Was ar			utopsy finding completion of	
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tal Rections The certificate ector, page	es l 2	5. Was case referred to medica	Ţ. 					26.Płace o	f Death (0	Check on	1 Yes 2	INU	1 1	es 2	No No
f Vital Physician: er this certificated or Tal director,		examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatien	t 2 🔲 I	ER/Outpa	atient 3	DOA O	ther;	Nursing I	Home 5 R	esidence	6 V Othe	er: Scene	
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Division pital or Attent ours after death teral Director: filled in by the		3 Suicide 6 Coul	not be 28e	. Place of Inju	ry - At hor	me, farm,	street, fac	tory, office buil	lding, etc.	28	Sf. Location (Str or Town, Sta	eet and N	umber or R	ural Route Nu	mber, City
Division o Hospital or Attending Hours after death Funeral Director: After	5	4 Homicide	mined (Sp	ecify)	Hous	se				Вг	1timore	e, Z93 ≥ , MD	o Gre	enmoun	L Ave
n 24 h	- 1 2	9a. Certifier 1 Certifying Pi	ysician: To th	ne best of my	knowledge	e, death	occurred at	the time, date	and place	e, and du	e to the cause(s) and ma	nner as sta	ted.	
S Tar With		2 🖳	and mar	ner stated.	ination and	d/or inve				urred at th					
2	² ²	9b. Signature and title of certifie	.1					29c. License r						onth, Day, Year	r)
	L	Yanuh Your	tull n	u)				O.C.M.	.E.			May 4,	2010		
	3	0. Name and address of person Pamela E. Southall, M			,	,	111 0	nn Chur - t	Daliti		04004				
	2	1. Date filed (Month, Day, Year)		ant Medic			IIIPe	nn Street, I	Daitimo	re, MD	21201				
Stat Registrå	~	Date mod (World) (Day, 18a))	3 2010	Deneu	- Signature	4.	park								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death A Pri Year **Physician** 5 30 AM 2010 Thelma Christine Trimper /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AGNES HOSPITA Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
July 29,1941 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 Months Days Hours Min Maryland Director 219**-**38-7059 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland i and Merital Hygiene. is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1 ☐ Yes 2 🙀 No Director Anne Arundel Glen Burnie 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 7807 Overhill 21060 USA Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 XNo Specify: White Specify: þ 3 ☐ Widowed 4 🎇 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own home 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any filing or other traumatic event otce. 17. Father's Name (First, Middle, Last) Be Frances E. Gordon Percy Lee Shockney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7807 Overhill Road, Glen Burnie MD 21060 Rita Fell -Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 4,2010 Baltimore Western Cemeterv 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 21. Signature of Funeral Service Licensee 2719 Hammonds Ferry Road Lansdowne MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) stroke **Physician** Days /Medical Due to (or as a consequence of): Examiner phalomalac Sequentially list conditions, the conditions of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Months The law requires that the death certificate be executed ZUYC signed by the attending physician and Due to (or as a consequence of) years Physician/Medical pronaru If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an has autopsy performed? Yes 2 No this certificate 1 Nes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one. Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ■Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

the Hospital or Attending Physician: in 24 hours the Funeral Dire within 2 To the I

Baltimore, Maryland 21215-0036

Box 68760

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Records,

Division of Vital

State

31. Date filed (Month, Day, Year)

29b. Signature and title of certified

29a. Certifier

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mohammad Valikhan 900 Cato 32 Aegistrar's Signature

and manner stated.

MD.

parks

Registrar

caton

29c. License number

AVP

0069177

29d. Date signed (Month, Day, Year)

MD

2010

21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear **Physician** AM M 4a. Facility Name (If not institution, give street and number) Mar 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayrian Medical Conter Baltimone If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 □ M 2**%** □ F Director 20,1938 216-36-7545 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinan must be notified at 1 ☐ Yes ¾☐ No Director MD Dunda1k <u>Baltimore</u> 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 101 Center Place 21222 United States Apt. 711 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑ No Specify <u>م</u> Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Mental Health Associate Ft. Howard V.A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David E. Turnbull Ada I. Degenhard ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any Injury or other trau once. 420 Carrollwood Road Baltimore, Maryland Mr. David Turnbull (Brother) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition UBurial 2 ∏Cremation 3 ☐ Removal from State Hilltop Service Corp. 5/5/2010 Towson, Maryland 4 Sonation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Lice 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Y 7922 Wise Ave. Dundalk, Maryland 29a. Part 1—Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 2 Hours Kespira toru /Medical consequence of): Examiner enmound PAYS Sequentially list conditions, and leading cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a conse wence of The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>\$</u> cate has been sig , page 2 should b 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 ☐ Yes 2 **N**6 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

31. Date filed (Month, Day, Year) 32. Regintrar's Signature

4940

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

SMITTA

RES-000

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For Amend	State of Mary Ltems 23a-29	yland / Depa a per dr. Cer	rtment of H tificate of D	06/2010d	lental Hyo	giene Reg. No. 🤈 🏻	חוח	11.016	
	1. Decedent's Name (First, Middle, Last)							2. Date of Death 3. Time of Death				
1	Physician/ Medical Sarah L. Talbott							$\begin{array}{c ccccc} April & 23 & 2010 & 3:57 & A^{\text{M}} \end{array}$				
		taminer 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of								ty of Death		
			Brighton Gardens Assisted Living Columb						How	ard		
	Funeral Director		5. Social Security Number 6. 214–24–2244	Sex 7. Age (In 1	n yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Aug 23	1921	9. Birthpl County Mary I	ace (State or Foreign and	
-	ow	1 h	Usual Residence of Decedent 10a. State 10b. County	140	Dc. City, Town or Loc	eation				10	Od. Inside City Limits	
rylan	permit. Targer and 2 should be med within 7 chous aner bean with the waryand permit. Targer half had be med within 7 chous aner bean with the waryand Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	cto	MD Howard Columbia 1 □ Yes 2X No									
le Ma		Director	10e. Street and Number 10f. Zip Code					10g. Citizen of What Country?				
vith #		al	7110 Minstrel Way 21045						USA		•	
Maryland 21215-0036		ed by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🍱 Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	lf If	Vas Decedent of His Yes, specify Cubar	n, Mexican, Puerto	cify Yes or No- Rican, etc.)		ace - America ack, White, e whit	tc.	
5-0 2 hou		Bet	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most o					na	16b. Kind of	16b. Kind of Business Industry Baltimore County		
121		To Be Completed	Elementary/Seconday (0-12) College (1-4 or 5+) life. DO NOT use retired) teacher					Public Schools				
Z 22												
and be file			The Haller's					ritta McCallister				
Duoi d			19a. Informant's Name/Relationship	(Type, Print)	19b. Mailin	g Address (Street a					ode)	
₹ 5 st			Terry Prahl/dau	ighter	871	4 Castle	rock Cour	t; Laur	el, Ma	Maryland 20723		
Baltimore, permit. Page 1 and			20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 0 Other (Spec	Removal from State	20b. Place of Dispo- cemetery, crem	sition (Name of natory or other place	a) [Date	20c. Location	- City or Tov	vn, State	
Balt permit.			21. Sign June Fineral Stylice Lice Ronald S	wade nirec	tor 22	Name and Address State And				ltimor	e Street	
		П	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediale Cause (Final disease or addition Colonic Stricture and Obstruction Approximate Interval Between Onset and Death 2 months									
Phy	siciali/	H										
	Medical	Ш	resulting in death)	Due to (or as a co							_ HOHEIO	
→	aminer	ايا	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):									
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ecute	g physician and ss the burial-transit	Examiner										
be ex	sician buria	dical										
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Division of Vital Records, P.O. Box 687 tal or Attending Physician: The law requires that the death certific	within 4.4 notes after the this certificate has been signed by the attending physician and to the Funeral Director. After this certificate has been signed by the tuneral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 poinths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of the second of the se	Fetal death 3	Ectopic pregnancy Other (specify)	у			ate of delive Ionth	ry Day Year	
P.O.	ned by e detac	y Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?									
ds, quires	en sig buld b	led	Colonic diverticulosis 1 Yes 2 No 3 Probably 4 Unknown									
Recor	ite has be	Completed by	Probable colon	cancer		24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No						
ian:	ortifica ctor, p		25. Was case referred to medical examiner?			26. Pla	ace of Death (Check				Assisted	
i ysic	his ce Il dire	잍	1 ☐ Yes 2 🛣 No		2 ER/Outpatien		4 LJ Nursing Ho	me 5 Resid	lence 6 🔀 Ot	her (Specify)	Living	
of ing P	Viter t unera	Certificate:	27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of injury (Month, Day, Ye	(ear) 28b. Time of injury	28c. Injury work	? _	28d. Describe h	ow injury occu	rred		
ior	death tor: A the f	<u>∯</u>	2 Accident Investigati 3 Suicide 6 Could not	he -	At home form etre		Yes 2 ☐ No	20f Leasting /C	Street and Alum	har as Ruml	Parta Numbar	
IVIS	Direction of the position of t	g	4 ☐ Homicide determine		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
Spital	ne Funeral I		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.									
e Ho		Medical	(Check only one) (Check one) (Check only one)									
To th	To the company		29b. Signature and title of certifier	10	14. O	29c. License	number		29d. Date sign	ed (Month, D	ay, Year)	
		ı l		II/I	m.D.	D56	531		May 01	. 2010		
				\sim		<u> </u>	J J I		11.0-7	, 2010		
			30. Name and address of person who	·	h (Item 23a) (Type, P	rint)	<u> </u>		220-3	, 2010		
	Stat		30. Name and address of person who Harry Li 8600 S 31. Date filed (Month, Day, Year)	nowden River	h (Item 23a) (Type, P	7rint) 301, Co1	<u> </u>			, 2010		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #5,9,11,17,18,19a-b,20a-c,22,per FH G903 5/18/10 TT

State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	tate of Maryland /	•	rtment of F tificate of D			giene Reg. No. 🥎 🦳	1.0	11017			
	Dhysisia	m/	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	th	Year	3. Time of Death			
	Physicia Medic	al	0 1 1 1 1	URNER				April	29 20	010	302 AM			
تعددا) Examin	er	4a. Facility Name (if not institution, give stree UNIVERSITY) of WAY KIND			Buchy	Location of Death		4c. County o	f Death				
	Funeral Director		5. Social Security Number 8700 6. Sex 1 M	7. Age (In yrs. last b	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl Ju ^{Month,} 123	, Year) 954	9. Birthpl Count 1ary	ace (State or Foreign y) unk and			
	ind show at	or	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Loc	ation				10	d. Inside City Limits			
	Maryla 28a-f s otified	irect	MD Baltimore	Coc	keys	ville					1 ☐ Yes 2 ♣ No			
	s 23a or 2 sust be no	Funeral Director	10e. Street and Number 10400 Greentop Road	l		10f. Zip Code 21030			10g. Citizen of Wi USA	nat Count	ry?			
9003	e filed within 72 hours after death with the Maryland ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Nas Decedent Ever in U.S. Armed Forces? Unk 1 ☐ Yes 2 ☐ No f Yes, Give Year or Dates.	lf 1	/as Decedent of Hi Yes, specify Cuba ☐ Yes 2X No	n, Mexican, Puerto Specify:	Rican, etc.)	Black	What Country? See - American Indian, ck, White, etc. White Susiness Industry Unk Stand 21201 - City or Town, State Ore, MD Of MD, Sinc. Approximate Interval Between Onset and Death Tribute to the cause of death? 3 Probably 4 Vunknown Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No				
Maryland 21215-0036	within 72 hor giene. er than "nat , the Medica	Completed	15. Decedent's Educat (Specify only highest grade of Elementary/Seconday (0-12)	College (1-4 or 5+)	6a. Decede (Give k life. DC	ent's Usual Occupa ind of work done d) NOT use retired)	ation unk uring most of work	king	16b. Kind of Bus	ib. Kind of Business Industry unk				
d 2	filed wi al Hygie d other event, ti	Be	17. Father's Name (First, Middle, Last)	unk K			18. Mother's Nam	ne (First, Middle, I	Maiden Surname).	unk				
ylar	ild be i Menta Iarked	2	Harold Spencer Rober				Dolores	E. Stolt	zfus					
Mar	permit. Page 1 and 2 should be filed Department of Health and Mental H Important; If item 27 is marked ot any injury or other traumatic even once.		19a Informant's Name/Relationship (Type, F John M. Kerney/ Att University of MD Med	orney 1cal System	102 ^{ili} v	Pennsy Creene	⁄1√an1a ^R ⁄A Street:	Ve. Suit Baltimor	e Yaryl	owsc	3ff, MD 21204			
Baltimore,	of Head of Hea	1	20a. Method of Disposition	20b. Place		ition (Name of atory or other place	1	Date						
ţį	tt. Page rtment rtant; I	9	1 Durial 2 X Cremation 3 Regr 4 Donation 5 Other (Specify)			natory,]	inc. 5/10	/2010	Baltimor	e, M	D			
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	icate be executed physician and s the burial-transit	al Ex	that initiated events c. = resulting in death) Last	Due to (or as a consequence	e of):					\top				
094	cate be physic the bu	edical	d							\pm				
Division of Vital Records, P.O. Box 68	To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months?	If yes, outcome of pregnancy I Live Birth 2 Fetal dea I Pregnant at time of death I Unknown		Ectopic pregnanc Other (specify)	у	-11	23d. Date Mont		'			
ls, P.0	uires that the signed by all the deta	by	Part II. Other significant conditions contrib	uting to death but not resulting	g in the ur	derlying cause giv	en in Part I.							
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ζ	Physi rthis o	€ 10 10 10 10 10 10 10 10 10 10 10 10 10	1 L Yes 2 K No	1 X Inpatient 2 ☐ ER/	Outpatient	3 DOA Othe	4 ☐ Nursing H		ence 6 Other					
ono	anding rath. rr: Afte	ficate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	work'	? Yes 2 □ No	Zod. Bosonigo III	ow injury occurred					
Divisi	ral or Atters after de la Directo	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	8e. Place of Injury - At home, building, etc. (Specify)	farm, stre	et, factory, office		28f. Location (S City or Tow	treet and Number n, State)	or Rural i	Route Number,			
	To the Hospital or Attending Physician; The la within 24 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page	Medical	(Check 2 Medical Examiner:	: To the best of my knowledge On the basis of examination and actioner: To the best of my kno	d/or investi	gation, in my opinio	n, death occurred a	at the time, date ar	nd place, and due t	o the cau	se(s) and manner stated.			
	To t With		29b. Signature and title of certifier	Buok_		29c. License	number +312		29d. Date signed (Month, D	ay, Year)			
			30. Name and address of person who compl	eted cause of death (Item 23a	a) (Type, Pr	int)		7/2/27	No	11	. D			
	Stat		22 Sown Gro 31. Date filed (Month, Day, Year)	32. Redistrar's Signature	sal	timore	MD	21201	Dur	11211	e Duek			
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland Desagtment of Pedith and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** harles 100Norde 29 2010 03 /Medical 4c. County of Death 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore m. 426 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Poreign Country) 7. Age (In yrs. last birthday) **Funeral** Year) Days Months Hours **₩**Z M 2□ F 76 215-28-5456 Director 00 MD Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 X No Director MO 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Mango 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ∏Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No Specify: \ A. + Specify: ≥ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Trucking 8 Machinist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Ann Fritze ပ္ Godfrey C. VonNordeck 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roy VonNordeck 501 S. Marlyn Ave., Essex, 21221, MD Baltimore, 20a. Method of Disposition
1 □ Burial 2 ℃ remation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 4/2/10 Glen Burnie, MD Atlantic Crem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licenses 22. Name and Address of Facility 2829 Hudson Street Skarda F.H. tros Baltimore, MD, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician aryngea disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-transit Exami be exec Due to (or as a consequence of): attending physician #ベイダ・イン Records, P.O. Box 68760 Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No the detached 9 Unknown 9 Unknown ģ signed I I be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No After this certificate 2 🗆 No 1 □Yes Division of Vital Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Injury at Work? To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MID D6063913 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

MID

Registrar's Signature

Michael Rotte, Gues,

31. Date filed (Month, Day, Year)

9103 Frenklin Square

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month PM atson 7.15 COME -010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death (Sing More (lin yrs. 54 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🛣 M 2 🗆 F Months Hours Min. 2-28-1956 Director 216-62-1358 MD Usual Residence of Decedent shov 10b. County 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director Baltimore na 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4916 Greencrest Road 21206 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Armed Forces Black. White, etc. Completed by 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 Black 1 Yes 2 X No Specify: If Yes, Give "natural", 3 Widowed Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Various Jobs <u>10th grade</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Jerome Watson Delois McCormick .. Page 1 and 2 should tment of Health and M tant: If item 27 is mai 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4916 Greencrest Road Balto, MD 21206 Delois Watson-Mother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other pla t Carmel Cem 5-7-2010 Balto, MD 21. Signature Funer Fervice Licenses 22. Name and Address of Facility March East F/H Mulan 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause Immediate Cause (Final PATOCELLULA Onset and Death Physician/ disease or condition resulting in death) Medical Examiner o (or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Pregnant at time of death 5 Other (specify) Month Dav 4 ☐ Pregnant 9 ☐ Unknown 2 🗌 No been signed by the should be detached 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has autopsy perform 1 Yes 2 Wo Yes 2 25. Was case referred to predical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital ည 1 Inpatient 2 ER/Outpatient 3 DOA after death.

Director: After this Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 27. Manne of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 🗆 No 2 Accider
3 Suicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) thin 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practice on: To the best of my however, death ordinary at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the I only one the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) MI sueen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TASNEEM AKHANI, 2835 SmITH AVE, SUITE 2B, BALTO MD 21289 SNEEm 31. Date filed (Month State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decement's Name (First Middle, Last) Month April Physician Villiamson 2:55 AM 30, 2010 tanes /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Good Samaritan Hospital 9. Birthplace (State or Foreign Country) 8. Date of Birth If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 M 2 ■ F Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b, County injury or other traumatic event, the Medical Examiner must be notified at 1 es 2 No MDDirector imore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or 21206 Ivenue USA thon by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Black 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) is marked other than Elementary/Secondary (0-12) 2 should be filed within and Mental Hygiene. 18. Mother's Name (First, Middle, Maiden Surname) Be Villiamson ar or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number Ave, Balto. , MD 21206 permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra 5632 Anthony 20b. Place of Disposition (Name of cemetery, cremator) or other place) 20c. Location - City or Town, State Date unK 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ballimore, MD Crarene Funeral Services 21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 140cardial /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Mellitas burial-transi rabetas Due to (or as a consequence of): Box 68760. attending physician pe Physician/Medical use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months?
1 Yes 2 Who Month Day Vear 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for P.O. 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cau<u>s</u>e given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed has been 24b, Were autopsy findings available prior to completion of cause of death?

1 ★★★ 2 □ No 24a. Was an certificate 2 □ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Pro ၉ 1 Papatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Natural (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie Chair 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 Loch Raven Boulevard, Baltimore Maryland 21239 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

MAY 06

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ eveland 2010 May 1734 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 4b. City, Town, or Location of Death Hospital Union Manorial Baltimore 5. Social Security Number 7. Age (In yrs, last birthday) Yrs. If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Months Days Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature!" any injury or other traumatic auce. 10c. City, Town or Location
Ba Himbre 10a. State 10b. County 10d. Inside City Limits Funeral Director 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country' 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Black 3 Widowed 4 Divorced Specify. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ton, Inc. Mail Clerk +cars Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ၉ L. Willis onnor Fannie Latane Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ida L. Willis, Daughter 2469 Shirley Avenue Baltimore, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State Eutus Memorial Park 10/2010 Baltimone, MD 4 ☐ Donation 5 ☐ Other (Specify) . Greene Funeral SVCS Signature of Funeral Service Licensee 22. Name and Address of Facility Kandalotan MD 21133 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ drati disease or condition Medical resulting in death) Due to (or a sonsequence of): **Examiner** months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit year resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Pregnant at time of death 5 Other (specify) Year ed by the a Yes 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: 잍 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State 6 Registrar

only one)

Signature and title of certifie

29c. License number

02,2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No./ Certificate of Death 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 2:30 AM 2016 WUDDY Physician MARY 4c. County of Death /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) BALTIMORE Examiner TOWSON MANOR CARE 9. Birthplace (State or Foreign 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 1 7. Age (In yrs. last birthday) Year) country 6. Sex Social Security Number Days 17,1922 Months Virginia **Funeral** 1 □ M 2 🔀 F 227-30-1611 88 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 📉 No 28a-f show th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Extradiger must be retilled at Dunda1k Director Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21222 7915 St. Monica Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 □Yes 2 □ No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after in neart of Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: White Baltimore, Maryland 21215-0036 þ 3X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Western Electric Assembly Line Worker 12 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary E. Morris Elzie E. Morris ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8614 Hickory Thicket Place Nottingham, MD 21236 19a. Informant's Name/Relationship (Type. Print) James M. Woody, Jr. (Son) Health a Department of Health Important: If item 27 any Injury or other tr 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Middle River, MD 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4/30/2010 Holly Hill Mem. Gdns. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Fundal Semice Licenses Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition DEMENTIA **Physician** disease or condition resulting in death) Due to (or as a consequence of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed burial-transi and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate 23d. Date of delivery 23c. If yes, outcome of pregnancy Year 3 Ectopic pregnancy Day 23b. Was decedent pregnant in the past 12 months? Month Live birth 2 Fetal death 5 ☐ Other (specify) Pregnant at time of death ☐Yes 2 110 the 9 Unknown detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? s been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Nonknown 2 INFARCTION Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has been rector, page 2 shoul 24a. Was an autopsy 2 No 1 ☐ Yes 2 NO 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To After this 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Date of Injury (Month, Day, Year) 27. Manner of Death 1 Matural funeral Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after death. To the Funeral Director: A 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 Suicide filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

State Registrar

LEUNARD 31. Date filed (Month, Day, Year)

29b. Signature and title certifier

RICHARDSON M.D. 1838 GREENE TREE RUAD # 300 PILESVILLE MO 21208 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

29c. License number

22

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend #2, per MD G903 5/6/10 TT
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Manth ZEPP-ALCORN 7:20 PM TTYA Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death TIMORE Social Security Number 8. Date of Birth March Day, Year) March 24,1936 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖺 F Months Days Hours 219-32-5338 74 Yrs. Director Ohio Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel 1 Yes 2X No Severn 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1622 Disney Road 21144 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 X No Specify: White 3

Widowed 4 □ Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) School Bus Driver Anne Arundel County Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Comer Anderson Barker Margaret Elizabeth Stumbo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs Joyce Bolin/ Daughter 1622 Disney Road Severn Maryland 21144 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State May 7 2010 Glen Haven Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD. 21. Signature of Funeral Service 22. Name and Address of Facility Singleton Funeral & Cremation eno Services PA 1 2nd SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ PNEUMONIA disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** REATITIS Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events OBSTRUCTIVE 8LEEP Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transil Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: ate has been signed by the attendin page 2 should be detached for use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month 5 Other (specify) Dav Year 1 Yes 2'D 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has perform 2 No Yes 2 No 1 Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Hospital Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 5 Pending injury 1 Tes 2 No Accident Investigation **Director:** Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature a 29c. License number RES -00i 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200 HNOVER STREET BALTIMORE 32. Reg trar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}20<u>10</u> April Physician/ 30 8:50 P. Elsie Mae Bartgis Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick 1539 Thurston Road Dickerson Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕅 F 1171071922 Maryland 218-50-4481 Director 87 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mentel Hyglene.

Hart, If flew 27, and Alentel Hyglene.

Hart, If flew 27, and the Alenter than "natural", or items 23a or 28a-f sho into or other traumatic event, the Medical Examiner must be notified at jury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21702 United States 8746 Walter Martz Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces 1 Never Married 2 Married 1 Yes 2 No Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white 3 ☑ Widowed 4 ☐ Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) dairy farmer farming Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Charles Edward Poole Emma Gertrude Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randy Bartgis / son 8746 Walter Martz Rd., Frederick, MD 21702 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition permit. Page 1 a
Department of IImportant: If ite
any injury or ot ⊠ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Mem. Gardens 5/4/2010 Frederick, MD 22. Name and Address of Facility Keeney & Basford Funeral Home 21. Signature of Funeral Service License MO1222 106 E. Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Advanced Dementia Medical Due to (or as a consequence of): Examiner Diabetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury Hypertension use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the hurial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be CVA Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) 4 Pregnant 9 Unknown Pregnant at time of death 1 Yes 2 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2X ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available page 2 s autopsy performed? Yes 2 X No prior to completion of cause of death? this certificate 1 Yes 2 No 24 hours after death.

• Funeral Director: After this certific leted filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 4 Nursing Home 5 Residence 6 Thomas people niece Other: ၉ 1 🗌 Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29c. License number 29b. Signature and title of Certifier 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

RO69310

CRNP / 1564 Opossuntown Pike, Frederick, Md. 21702

5/3/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ George Robert Briddel1 7: 40 AM 04 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Coastal Hospice at Salisbur the Lake Wicomico 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country)
Maryland 218-20-9095 1 🛣 M 2 🗆 F Months Days Hours Min. (Month, Day, Year) 03-31-1928 82 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: I firem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1000 Caravan Way 21804 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces?
1 ★Yes 2 No
If Yes, Give
Year or Dates. 1946-47 Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Owner/Operator Upholstry Business Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul Briddell Annie Briddell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Jane Briddell/wife 1000 Caravan Way, Salisbury, MD 21804 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 MBurial 2 Cremation 3 Removal from State Beechwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 04/21/2010 Princess Anne, Maryland 21. ignature of Funeral Service Licensee Hinman Funeral Home M00295 11673 Somerset . Princess Anne. 3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between mmediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) CHRONIC OBSTRUCTIVE Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events southing in death). Examine Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician the burial Physician/Medical Box 68760 nding pass as t IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ for in the past 12 months? Day Year Pregnant at time of death signed by the a *2 🗌 No Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2/ No 1 Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital 2 INO Other: မ 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify HO) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pendina after death.

Director: Aft
d in by the fur 2 Accident 3 Suicide Investigation 1 🗌 Yes 2 🗆 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined building, etc. (Specify) 24 hours a Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the I within 2 To the I only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 00058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Donald Eugene Bolt

Physician /Medical **Examiner**

120/10

DAD

4/6/2

1 - State Registrar

4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Atlantic General Hospital Berlin 8. Date of Birth (Month, Day, Year) 7/7/1942 5. Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 M 2 □ F 220-36-8464 67 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location ms 23a or 28a-f show Director MD Worcester Ocean City 10e. Street and Number 10f. Zip Code 406 Bayshore Dr. Unit C 21842 Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any Injury or other traumatic event, the Medical Exeminer or 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify. 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Amanda Porter William D. Bolt ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ray D. Bolt / son 1543 Teal Dr., Ocean City, MD 21842 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Cape Henlopen Crem. 4/22/2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. land. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to for as a consequence of) Examiner Sequentially list conditions, if any leading leading leading cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of signed by the attending physician and deetached for use as the burial-tran Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð Completed 24a. Was an autopsy performed? this certificate **Division of Vital** e Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 10064120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DN 7 Berlin MD Zeeshan Health way

2010 4:45 P 4c. County of Death Worcester Birthplace (State or Foreign Country) VA 10d. Inside City Limits 1 XYes 2 No 10g. Citizen of What Country? USA 14. Race - American Indian. Black, White, etc Specify: white 16b. Kind of Business/Industry Trucking Company Frankford, DE Approximate Interval Between Onset and Death 23d. Date of delivery Month Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 ☐ Yes 28d. Describe how injury occurred Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

APR 2 2 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Evelyn Raye Bennett AMPI 21, 2010 12:55 p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗌 M 2 🔼 F Months Days Hours Min. Feb. 14 Pay, 1922 Countrillew York 068-38-5590 Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 3126 Gracefield Road 20904 LISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ■No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse **Hospital** Be 17. Father's Name (First, Middle, Last) Abraham Fisch Mother's Name (First, Middle, Maiden Surname)
 Mary Lifschitz ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Newley Namber, City or Town, State, Zip Code)
11970 Little Patuxent Pkwy., Columbia, MD 21044 Gary M. Bennett/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott April 22. cemetery, crematory or other place) 1 Burial 2 🔀 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, VA 2010 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween nset and Death Immediate Cause (Final Physician/ Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Septic Shock wk. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): signed by the attending physician and d be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Congestive Heart Failure yrs. Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 Live Birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Pulmonary Hypertension, Right Hydronephrosis, 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an Peripheral Venous Disease with Venous Stasis of Left Leg autopsy perforn 1 Yes 2 No Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Yes 2 **2** No 1 Ninpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State)

To the Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 ours after death.

eral Director: After this certificate Pfilled in by the funeral director, page within 24 hours a To the Funeral I

State Registrar

DHMH 17 Rev 7/2009

Medical

29a. Certifier (Check

29b. Signature and title of certifier

Name and address of person w Barbara Supanich,

32 Registrar's Signature

Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

ed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, MD 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2010 Month **Physician** April 23, 11:00a.M Mae Virginia BONCORD /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death **Examiner** Hagerstown Washington Golden Living Center If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Yea 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday 6. Sex **Funeral** Months Days 1 □ M 2 🕅 F Maryland 89 212-24-5821 March 13,1921 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at Maryland Washington 1X Yes 2 □ No Hagerstown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? other traumatic event, the Medical Examiner must be U.S.A. 426 East Washington Street 21740 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No white Specify: þ 3K Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) her own home homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Maxwell Bowers Helen Virginia Moore 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health an
Important: If item 27 is n
any injury or other Beverly Bragunier - niece 109 Bester Street, Hagerstown, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition April 27 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rose Hill Cemetery Hagerstown, Maryland 2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 5 years disease or condition resulting in death) /Medical Du to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28d. Describe how injury occurred 27. Manner of Death

certificate be executed P.O. Box 68760, attending physician Division or Vital Records, been s has certificate Physician: this

with the Maryland

death v

of filed within 72 hours after de Il Hygiene. Other than "natural", or Item

and Mental Hygiv

and 2 should be

Baltimore, Maryland 21215-0036

use as the burial-transi signed by the detached page 2 To the Hospital or Attending Physical within 24 hours after death.

To the Funeral Director: After this of completely filled in by the funeral director.

1 Natural

29a, Certifier

Certification: 2 Accident 3 ☐ Suicide 4 Homicide

Medical

State Registrar

5 Pending investigation 6 ☐ Could not be

determined

28a. Date of Injury (Month, Day Year)

28b. Time of

28c. Injury at Work? 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

D28365

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

HAFI 32. Registrar's Signature

nuil Street Hegistern 21740 368

2H-1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Janet Mildred Boggs 6:55 A M 2010 nat Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🔀 Hours Del Monty Day 1 934 ^cvermont **Director** 008-24-3218 75 Usual Residence of Decedent or 28a-f show e notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Williamsport Maryland Washington 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 21795 IISA 11311 Sword Road items "natural", or item ledical Examiner m 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify. Completed White Year or Dates Page 1 and 2 should be filed within 72 hour ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natuuy or other traumatic event, the Medical ury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Bryant Rollin Prior Doris Ava Gorton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11311 Sword Road Williamsport, Maryland 21795 Gary D. Boggs - Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1X Burial 2 ☐ Cremation 3 ☐ Removal from State April 29,2010 Williamsport, Maryland Greenlawn Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) Signat f Funeral Sarvice Lice see Osborne Adenerally Home, P.A. MD 21795 425 S. Conococheague St.Williamsport, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) that the death certificate be executed and as the burial-tran consequence of resulting in death) Last signed by the attending physician be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcom- of pre/nancy 23b. Was decedent pregnant 23d, Date of delivery Live Birth 2 Fetal dead Pregnant at time of death Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months Month Year 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician: The law requires 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Yes been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 Yes 2 🗌 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No ျ Inpatient 2 - ER/Outpatient 3 - DOA In the fruction within 24 hours after death.

To the Funeral Director. After this of the funeral director and the funeral director. 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending work? 2 Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗀 Homicidé determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

5H-7

State Registrar

29b. Signat

31. Date filed (Month)

egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Mary		epartmei Ce <i>rtificat</i>			vientai Hy	gien Reg. N	0010	W-0.00	1231	
	Physicia		1. Decedent's Name (First, Middle, La Lillie L.	Bowman					2. Date of De Month	eath 4 D	ay /9 Year 20		ime of Death 4:05 M	
	Medic Examin		4a. Facility Name (if not institution, giv Coastal Hospice		C		Town, or Lo	cation of Death			c. County of Dea	th		
	Funeral Director		5. Social Security Number 6. 9 217–30–8690		yrs. last birthd	ay) If Unde	r 1 Year If	Under 24 Hrs. lours Min.	8. Date of Bir (Month, Da 12/14/	th 193	9. Bi		State or Foreign	
	land show dat	tor	Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town o	r Location			· · · · · · -			10d. Ins	ide City Limits	
	e Mary r 28a-f notifie	Direc	Maryland Wicomi	.co	Salis		p Code			10: 0	200		Yes 2 No	
	n with th is 23a o nust be	Funeral Director	1505 Lilac Driv	7e			21804			10g. C	itizen of What Co USA	ountry?		
9600	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fur	11. Marital Status 1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	'n U.S.		dent of Hispa cify Cuban, N 2 🛣 No S		ecify Yes or No- Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: White			
215-	n 72 ho s. an "nat Medic	mple	15. Decedent's I (Specify only highest gi Elementary/Seconday (0-12)		(C	ecedent's Usu Give kind of wo ie. DO NOT us	rk done durir	n ng most of work	ding	1	Kind of Business	,		
ma 1213	d withi	Be Co	17. Father's Name (First, Middle, Last)	_	- school bus drive						ard of E	duca	tion	
Second Specify: Second Specify: Specify									. Nicho		i Surname)			
	nd 2 shoul ealth and m 27 is m		19a. Informant's Name/Relationship (Jack Bowman/spou		19b. N	Mailing Addres 505 Li	s (Street and lac Dr	Number or Rur •, Sali	al Route Numbe sbury ,	MD	or Town, State, Zi 21804 	p Code)		
LillteBaltimore,	:. Page 1 a tment of H tant: If ite jury or oth		20a. Method of Disposition 1									,		
Ball	permit Depar Impor any in once.		21. Signature of Funeral Service Licen	Bland		1011g	waydre r u now Hi	Haral H	lome Pro	fes: ury	sional A	SSOC 04	iation	
	Physician/	726	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MRTASTATIC ANCRRATIC CACINOMA Due to (or as a consequence of):											
1	Medical Examiner		resulting in death)			- Academic Control							•	
	ted I nsit	Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	b. Due to (or as a con	sequence of):									
0	icate be executed physician and is the burial-transit	lical Exa	that initiated events resulting in death) Last	Due to (or as a con	consequence of):									
09289		/Med	IF FEMALE:	23c. If yes, outcome of pre	egnancy			-		\neg				
. Box	he death certific y the attending ched for use as	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1									Day	Year	
ds, P.O	requires that the de been signed by the s should be detached	<u>م</u>	Part II. Other significant conditions of	contributing to death but no	ot resulting in t	he underlying	cause given i	in Part I.			use contribute to			
The part of the pa											prior to death?	topsy find completio	lings available n of cause of o	
/ital	ysician: The is certificate director, pag		25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	2 ☐ ER/Outo	ationt 3 🗆 D		of Death (Chec		dono.E/	Other (Once	icilto	CPICE	
27. Manner of Death 27. Manner of Death 28d. Date of injury 28d. Time of injury 28d. Date of injury											ry occurred	:iiy)]		
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	he Hospi in 24 hou he Funer pleted fill	Medical	(Check / 2 L Medical Exam	rsician: To the best of my kinner: On the basis of examin se Practioner: To the best of	nation and/or in	vestigation, in	my opinion, d	leath occurred a	t the time, date a	and place	e, and due to the	cause(s) ar	nd manner stated.	
	To the within 2 To the comple		29b. Signature and title of certifier			290	DOO.			29d. Da	ate signed (Monti	h, Day, Yea	ar)	
	31		30. Name and address of person who	1 00	(Item 23a) (Typ	pe, Print)	SA	58410 LYBU	ay	m	n r	180	2	
	Stat Registra	te ar	31. Date filed (Manth Pay, 202) 20	Registrar's Si	ignature	back			7					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Irene Belcher 1:30 2010 Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Will mico 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth Social Security Number If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 1 □ M 2 🗚 F Months Days Min. 04/02/1932 Washington, DC **Director** 578-38-6590 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important I frem 27 is anarked other than "natural", or items 23a or 28a-f sho important If item 27 is anarked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Wicomico Salisbury Marvland 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 1400 Limrock Court 21804 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No 1 Yes 2 No Specify If Yes, Give Year or Dates white Specify Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) office clerk clerical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fred Markowitz Ann Kishter 19a. Informant's Name/Relationship (Type, Print)
Sharon Belcher/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3556 Phillips Rd., Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Forest Lawn Cemetery 4/23/2010 Norfolk, VA Signature of Funeral Service License Name and Address of Facility
HOITOWay Funeral Home Professional Association Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ CARIOMYOPA TH disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Ducito (or as a consequence of): Examin and -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 9 Unknown ed by the a signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 nknown 24b. Were autopsy findings available prior to completion of cause of has page 2 s autopsy performed? death? To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes∕ 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1+OSPICA ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 Yes 2 No Natural 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \square Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 10058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) thum gistrar's Signature APR 22

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Jeffrey Allen Blevin	1- I	For State	State	e of Maryl	and / Depa <i>Cei</i>	artment of rtificate of		d Mental I	Hygiene	Reg. Na. 20	10	14.233			
Physician/ Medical Examine	1.	Decedent's Name		•	Ble	vins			2. Date of D Month April 30	eath Day Year		Time of Death 0825 hrs			
	4a		not institution, g	give street and number) 4b. City, Town, or L Hagerstown						4c. County o					
Funeral Director		Social Security No.	1275	Sex M 2 F	7. Age (In yrs. I		If Under 1 Year Months Day			Birth(MM/DD/YYYY)		elace (State or try) MD			
d d d d d d d d d d d d d d d d d d d	10		Decedent 10b. County Washii	nation		Town or Location		·				Od. Inside City Limits			
the Maryland a or 28a-f show tiffed at once. Director	10	e. Street and Num				J	10f. Zip Code	+0		10g. Citizen of Wha	at Country	n			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic ovent, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11 1 3	. Marital Status Never Married Widowed	d 2 Marrie		2 1 No	If Ye	S Decedent of His es, specify Cubar Yes 2	, Mexican, Puer		White,		n Indian, Black, He			
5-0036 cd within 72 hours is tygiene. other than "natura the Medical Exami Completed b	1	5. Decedent's Edu Elementary/Secon			de completed) 1-4 or 5+)	during mo	s Usual Occupates of working life	DO NOT use re		Engine		ng Co.			
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and 2 should and 2 should feath and Me tem 27 is ma traumatic or	_	<u> Hever</u>	E. DIE	Type, Print)	3rother	19b. Mailing	Address (Stree	t and Number o	Rural Route N	umber, City or Town					
Baltimore, permit. Pages I an Department of Hea important: If iten njury or other tr	1 4	a. Method of Dispo Burial 2	Cremation 3 Other Specif	Y/A	rom State	rematory or oth	,	latory ⁵		20c. Location - 0	sbun	g, MD			
Balt permit. Depart Impor injury		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thom pson Funeral Clear Spring md. 21722													
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ital Fician:	25.	Was case referre examiner?		Hospital:		FB(O) to all and		of Death (Check		7					
n of Vil ding Physia a. After this funeral din	27. 1	1 Yes 2 Manner of Death Natural	No Pending	28a. Date		ER/Outpatient 28b. Time of Inj	ury 28c. Injur	Other Nurs		Residence 6 🗸		cene			
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Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	298			ian: To the bes	st of my knowledg				d due to the car	use(s) and manner a e and place, and due		ause(s)			
Me T × T	29b	o. Signature and til	tle of certifier	ne Yhu	ll		29c. License O.C.M			29d. Date signed May 1, 2010		Day, Year)			
_		Name and addres			se of death (Item : dical Examine	,	nn Street, Ba	Itimore, MD	21201						
State Registrar		Date filed (Month,	MAY*0 6	2010 ^{32. Re}	gistrar's Signatur	e 1. A	outled.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death APRII Physician/ 2010 Year ELLIOTT BRISTOW 10:15 p^M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 16 Stemmers Run Rd. Earleville Cecil 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Min. 1 🗆 M 2 🕱 F Hours Dec 29 1923 Mary land Director 86 217-12-4705 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must hamorismant 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Cecil 1 Tes 2 No Earleville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16 Stemmers Run Rd. 21919 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give 2X No Maryland 21215-0036 1 ☐ Yes 2X No Specify White Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ James Bronna Elliott Bertie Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Macey McCloskey (daughter) Box 64 Earleville, MD, Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State St. Stephen's Cem. 4 ☐ Donation 5 ☐ Other (Specify) 5/7/10 Earleville, MD. nature of Funeral Savior Lice 22. Name and Address of Facility
Galena Funeral Home of Stephen L.
118 West Cross St. Galena, MD. 21 M00510 23a. Rart - Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atte in the past 12 months?
1 Yes 2 XNo Month Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed after death.

Director: After this certificate Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death Certificate: 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) **Natural** 5 Pending Accident 1 Yes 2 No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in by determined within 24 hours a

To the Funeral D edical 29a. Certifier Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29b. Signat-056811

State Registrar 30. Name and address of page

BHOK

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

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who completed cause of death (Item 23a) (Type, Print)

FRAMUNIA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month **Physician** NINA KATHRYN BOLES 0/0 11:45 am pri /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Plata Center a LIVISTA 8. Date of Birth (Month, Day, Year) 6 - 20 - 1922 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 □ M 2 🟋 Months Days Hours Min. MD Country) 225-28-5646 87 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits 28a-f show event, the Medical Examiner must be notified at Director MD. CHARLES LA PLATA 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 9439 MAY DAY STREET 20646 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 🎇 No Specify: Specify:WHITE ò 3 Widowed 4 □ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than College (1-4or 5+) Elementary/Secondary (0-12) OFFICE MANAGER FRANKLIN MARBLE & TI 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be AUGUSTUS WELCH LENA ARNOLD ၉ Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Depar ment of Health a Important: If item 27 is any Injury or other tra DENNIS WOODRUFF-SON 9439 MAY DAY STREET LA PLATA, MD. 20646 Health 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1♥ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) TRINITY MEM. GARDENS 5-1-2010 WALDORF, MD. 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MARYLAND 20646 M00479 21. Signature of Funeral Service Licenses 23a. Part 1. En or the disease, or complications has shock, or heart failure. List only one cause of Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 ☐ Other (specify) P.0. 9 Unknown cate has been signed page 2 should be det out not resulting in the Underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions Records, ≥ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform Vital 1 □Yes 2 No 2 □ No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medic director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To Division of this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: completely filled in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 🕍 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of of tifie 29c. License number 29d. Date signed (Month, Day, Year)

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Registrar

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Registrar's Signar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene Fir, RG FCHD 4/29/10 (Certificate of Death Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0840 Frances A. Cover Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington Hagerstown If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 Virginia 7. Age (In vrs. last birthday) 8 Date of Birth Funeral 3-40-6998 Months Days Hours Director 87 Yrs Usual Residence of Decedent 28a-f show 10b. County 10a. State notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Washington Sharpsburg 10e Street and Number ō 10f. Zip Code 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral 18520 Mt. Lock Hill Rd. 21782 United States filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify: Specify: Completed 3 X Widowed 4 Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene, item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) own home homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Roy Shewbridge Mary F. Waters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 she Department of Health an Important: If item 27 is any injury or other trau once. 22318 Armstrong Dr.. Sue Ann Yingling/ daughter Leonardtown. MD 20650 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Olivet Cemetery Mt 4/23/2010 Frederick, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facilities Reeney & Basford Funeral Home garzeller Kr MO1222 Church St. Frederick, MD 21 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset a Death shock, or heart failure. List only one caus an each line Immediate Cause (Final Physician/ disease or condition resulting in death) - Medical ue to (or as a consequence of): Examiner consequence of: Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed ig physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Pregnant at time of death Dav Year should be detached g 🖂 Unknown Unknown signed by Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 performed? Yes 2. No 1 Yes 2 No Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **Y**No 1 🗌 Yes မ 1 Manpatient 2 ER/Outpatient 3 DOA e Hospira.

n 24 hours after death.

he Funeral Director: After th 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural Accident 5 Pending 1 Yes 2 🗌 No Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) npleted filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 2. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) a seem wid mma 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 9:30 a.M \pri] Janice Lynn Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** <u> 26601 Forest Hall</u> <u>Mechanicsville</u> Mary's 9. Birthplace (State or Foreign Country) Hawaii **Funeral** Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Min. 08/11/1953 1 M 2 X F Director 575-66-7826 57 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No Maryland | St. Mary's Mechanicsville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 26601 Forest Hall Drive United States 20659 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🛣 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Construction Permit Expeditor Construction Permits Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Tony Hamilton Mather Margaret Hazeline Teer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Forest Hall Drive, Mechanicsville, MD 26601 20659 <u>James M. Cain/Husband</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Brinsfield-Echols Cre 04/27/2010 Charlotte Hall, MD 21. Signature of Funeral Service 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Ward M <u>Danielle</u> 22955 Hollywood Rd., Leonardtown, MD 20650 M01403 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ogset and Death Physician/ CA ovary disease or condition Medical resulting in death) Due to (or as a cons-o) ence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of). cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year 4 ☐ Pregnant at time of death g ☐ Unknown signed by the a Yes 2 No 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 Yes 2 No Yes after death.

Director: After this certified in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 X No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) 24 hours a Funeral I Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29d. Date signed (Month. Dav. Year) D50350 04 [26] 2010 6 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frank Kriger, $M \cdot D$ 40900 Merchants La., Leonardtown, MD 20650 31. Date filed (Month, Day, Year) egistrar's Signature 28 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Marylar		rtment of F tificate of I		-	giene Reg. No. 2 A i	0 11 220			
	D		Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	3. Time of Death			
	Physicia /Medic		Alice Lucille Cobb					April	2 ³ 2010	3:45 P ^M			
	Examin	er	4a. Facility Name (If not institution, give str	reet and number)					4c. County of Dea				
200			18819 Rolling Rd. 5. Social Security Number 6. Sex	7. Age (In yrs.	last hirthday)	Hagersto	OWN If Under 24 Hrs.	8 Date of Birt	Washingto				
	Funeral Director			M 2 X F 73	Yrs.	Months Days	Hours Min.						
	pur M		Usual Residence of Decedent 10a. State 10b. County	10c Ci	ty, Town or Lo	nation				10d. Inside City Limits			
	Maryle f sho	or	Maryland Washington		erstow					1 ☐ Yes 2X No			
	the 7	Directo	10e. Street and Number	i courrey mag	,0101011	10f. Zip Code			10g. Citizen of What C	ountry?			
	h with		18819 Rolling Rd.			21742	2		U.S.A.				
	r deat	Funeral	TTT Marital Status	. Was Decedent Ever in U Armed Forces?	.S. 13. \	Was Decedent of H	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No-	14. Race - Am Black, Whi				
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exp. niner must be rediffied at once.	by Fi	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		l∐Yes 2∭ No	Specify:		Specify: W				
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Maryland 21215-0036	Ild be fental rked o tic eve	To Be	Clifton R. Bradish	L					er Bradish				
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∑ ()	and 2 lealth m 27 her tr		Robert E. Cobb, Sr						MD 21742				
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Baltimore,	nit. Pa artmel ortant injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee			s Cemete			Clear SPri Fiery Fun	ng, Maryland			
Ba	Depart Impo		Dunale N	Zen	140			_	Hagerstown,				
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	Physician		Immediate Cause (Final disease or condition	Sev	erk	2 Cle	8 Effic	Don	0865	Onset and Death			
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):	110	apl	Fai	luco,				
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	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (1) and the cause of	110	10gg	eku	20	LLS					
20,	icate be executed physician and the burial-transit	EX	resulting in death) Last	Due to (or as a conseq	usnee of):	nato	T.A.	(W)	Mesto				
68760	tificate be executed g physician and as the burial-transit	edical	d.	7-1	run	11-0							
		n/Me	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregna		3=			23d. Date of de	elivery			
. B	The law requires that the death cer ate has been signed by the attendir bage 2 should be detached for use	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of a 9 ☐ Unknown		Ectopic pregnance Other (specify)	у		Month	Day Year			
P. 0	hat the de d by the a letached	Phy	9 ☐ Unknown Part II. Other significant conditions control		ulting in the ur	nderkving cause give	en in Part b	23e Did to	obacco use contribute	to the cause of death?			
Records,	uires that signed l	d by	(luf	ulatoes	of .	Oysar	ncfic	7 101		Probably 4 Unknown			
S	s been s	lete		()	/	11		24a. Was		utopsy findings available			
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		Be C	25. Was case referred to medical examiner?				26. Place of Deat			0 2010			
	Physic this cal dire	၉	1 Yes 2 No Ho	spital: 1 Inpatient 2	·		4 LI Nursing H		dence 6 ☐ Other (Sp	ecify)			
Division of	ng l	Certification:	27. Manner of Death 1	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	Worl	yat ⟨? Yes 2 ∐No	28d. Describe h	now injury occurred				
NISI N	Attendi ar death. ector: A by the fu	ifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At h	ome, farm, stre			28f. Location (S	Street and Number or F	Rural Route Number,			
ā	ital or irs afte ral Dir led in	Ser	4 I Torrieds	building, etc. (Opeon				City or Tov	wi, State)				
	le Hospital or Att n 24 hours after de le Funeral Directo bletely filled in by t	Medical		clan: To the best of my known: On the basis of examination and manner stated.									
	To the twithin 2 To the I Complet	Mec	29b. Signature and title of certifier	and manner stated.		29c. Licens	e number		29d. Date signed (Mor.	th, Day, Year)			
	->-0		K e	ue no.		200	04502	37	APRIL 26	2010. UD 2740.			
1	1	Ì	30. Name and address of person who dom	pleted cause of death (Iter	n 23a) (Type, I	Print)	autine	711 8	2 HAG 1	W 21716			
Dr.	1-15		31. Date filed (Month, Day, Year)	32. Røgistrar's Signa	2L	460	mude	w A	1101	27.70			
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2010 Pau1 Coffren April 6:00 a. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 22269 Zacks Way St. Mary's Leonardtown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 🛣 M 2 🗆 F Months Days Hours Min. (Month, Day, Year) 01/02/1959 Director 216-80-1477 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits notified at Director 28a-f 1 Yes 2 X No Maryland St. Mary's Leonardtown 10e. Street and Number 10g. Citizen of What Country? ms 23a or Funeral 22269 Zacks Way 20650 USA 12 Was Decedent Ever in LLS 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc. ò þ 1 Never Married 2 K Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify Specify: "natural" 3 Divorced 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Construction Company Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) r is marked o 2 Coffren Gertrude Murphy Walter L. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 22269 Zacks Way, Leonardtown, MD 20650 Carol A. Coffren/Spouse Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1X Burial, 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) $4-29\overline{2}010$ Leonardtown, MD 4 Donation 5 Other (Specify) Charles Memorial Gardens 22. Name and Address of Facility
Brinsfield-Echols Funeral Home, P.A.
30195 Three Notch Rd., Charlotte Hall, MD 20622 M00817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Caucinoma disease or condition Medical resulting in death) Due to (or as a consequen - 1) **Examiner** Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Exami burial-transit Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death sate has been signed by the page 2 should be detached 9 Unknown g 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performed? death? ours after death.

Jerral Director: After this certificate I filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Yes 2 L No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum_{\text{Nursing Home}}\) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29d. Date signed (Month, Day, Year)

State Registrar

26840 Point Lookout Rd., Leonardtown, MD 20650 31. Date filed (Month . Registrar's Signature

Rakhi Krishnan, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D60888

10

26

M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2010 Physician/ April 25. Emma Lucille Clark 12:45 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 39078 Holly Drive Mechanicsville St. Mary's 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖼 F Months Hours 5-(Month, Pay, 1Year) 278-20-2217 Kentucky 92 Yrs. Director Usual Residence of Decedent show of Health and Mental Hygiene. item 23a or 28a-f shor item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland St. Mary's Mechanicsville 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Completed by Funeral United States 39078 <u>Holly Drive</u> 20659 Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 🗆 Yes 2 🛣 No White If Yes, Give Specify: 3 Midowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker At Home Be 18. Mother's Name (First, Middle, Maiden Surname)
Mahalia (Unknown) 17. Father's Name (First, Middle, Last) ဂ္ Paris Floyd McKinney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol A. King/Daughter 39078 Holly Drive, Mechanicsville, MD 20659 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot Beckley, West Virginia 4 ☐ Donation 5 ☐ Other (Specify) 4-29-2010 Calfee Cemetery 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., Signature of Funeral Service 30195 Three Notch Rd., Charlotte Hall, MD 20622 MO0817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** 21145 Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying nerosclevopo been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 1 ☐ Yes ∠ L 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy performed After this certificate has funeral director, page 2: 2 🖳 No 1 Yes Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Aesidence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate; 28d. Describe how injury occurred 1 Natural 5 Pending injury n 24 hours after death.

Funeral Director: A leted filled in by the fu Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed

within 2 To the I

State Registrar (Check

only one) 29b. Signature and title of contifier

30. Name and address of

Dr. Manoj Panwala, M.D., 37767 Market Drive, 31. Date filed (Month, Day, Year) 32. Registrar's Signature

erson who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) 6 2

Charlotte Hall, MD 20622

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 20°, 201°0 Nadezhda V. Chernyak М 1820 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral 1 □ M 2 🕱 F Hours Min (Month, Day, 8 / 0 9 / 60 Director 216-65-0409 Russi show 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director ral", or items 23a or 28a-f s Examiner must be notified MD Montgomery Rockville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12712 Veirs Mill Road #103 20853 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 😾 Married 1 ☐ Yes 2 😾 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other tha ury or other traumatic event, the I Caretaker Elderly care 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည unknown Lubov Kruglova 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20853 Anatoliy Chernyak/Husband 12712 Veirs Mill Road #103 Rockville, Md 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 😾 Cremation 3 ☐ Removal from State Chesapeake Crem. 4/26/2010 4 Donation 5 Other (Specify) Beltsville, Md. . Signature Junaral Segur PHILIP OF TWALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Metastatic breast cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Physician/Medical Examiner if any, reauling to immediate cause. Enter Underlying Cause (Disease or iinjury Due to tor as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this confidence because the control of the Funeral Director of th attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Live Birth 2 ☐ Fetal deal ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No ate has been signed by the atte page 2 should be detached for Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 X No Yes nin 24 hours after death.

the Funeral Director: After this certifical pipted filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 🛂 No 은 1 Yes 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🔼 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

Registrar

only one)

29b. Signature and title of conflier

31. Date filed (Month, Day, Year)

Ira Rabin M.D.

APR 22 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D0061887

1500 Forest Glen Road Silver Spring, Md 20910

29d. Date signed (Month, Day, Year)

April 21, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Physician Market Examiner The first of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Circulate) in Play 1 tail history in Course in Pl	rs after dea	2	3 Widowed 4	4 Divorced	If Yes, Give Year or Dates:		1	Yes 2	X No :	specify:		116h	1000		
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Physician Market Examiner The first of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Circulate) in Play 1 tail history in Course in Pl	Ore, M ges I and 2 it of Health it If item 2 other traur		20a. Method of Dispositi 1 X Burial 2 C	ion Cremation 3		20b. F State	crematory or otl	ner place)							
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The state of the s	ox 6876 ath certificat attending ph or use as the	sician/M	3b. Was decedent pregr past 12 months?		1 Live birth 4 Pregnant		2 Fe			Ectopic pregna	ancy	23		Da	y Year
29b. Signature and title of certifier 29c. License number O.C.M.E. April 19, 2010 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	O. Bo at the de d by the tached f					ath but not re	esulting in the u	nderlying	cause give	en in Part I.	23e. Did	tobacco	use contribu	ite to th	e cause of death?
29b. Signature and title of certifier 29c. License number O.C.M.E. April 19, 2010 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	S, P. quires that a signed and be de	ted by													bly 4 Unknown psy findings available
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29b. Signature and title of certifier 29c. License number O.C.M.E. April 19, 2010 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Ruor Town, State) 3 Suicide 6 Could not be determined (Specify) Local Street 4 Homicide (Specify) Local Street														
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Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201		Ě	29b Signature and title	of certifier	Polo	L s		29c.							n, Day, Year)
							Examiner		nn Stre	et, Baltimoi	re, MD 212	01			
State 31. Date filed (Month, Day, Year) Registrar APR 2 2 2010 32. Registrar's Signature APR 2 2 2010			31. Date filed (Month, Da APR	2 2 2 20			8. pa	Ne.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 3, Mary Emma Covell 2010 10:00 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick **Examiner** Glade Valley Nursing & Rehabilitation Walkersville Center 7. Age (In yrs. last birthdav) If Under 1 Year 6. Sex If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 💢 86 Months Days Hours Min Oct. Pay, Year923 215-18-1413 Mary land **Director** Usual Residence of Decedent show 10h. County 10c. City, Town or Location within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho 10d. Inside City Limits Director Frederick Frederick Maryland 1 ☐ Yes 2 X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 7189 West Sundown Court 21702 Funeral 12 Was Decedent Ever in U.S 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent 2.... Armed Forces? 1 ☐ Yes 2 🔀 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 □ Divorced Specify White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene tant: If item 27 is marked other than ' ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Tyson Brandenburg Carrie M. Plunkard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) er 2809 Roderick Road, Frederick, MD 21704 Mrs. L. Jean Rhinehart, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Olivet Cemetery Important; I any injury o May 7, 2010 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service ²Klame and Address of Ballsford PA Funeral Home M00255 106 East Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or impury that initiated events resulting in death) Last the burial-tran and Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No page 2 should be detached for Month Pregnant at time of death Day Year 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death, but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 1 ☐ Yes 2 ☐ No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other ٩ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manger of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide 28f. Location (Street and Number or Rural Route Number, determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of centili 29c. License number 29d. Date signed (Month, Day, Year) May 3, 2010 pleted cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 001

strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month O 4 Thomas Dashiell 0152 10 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Regional Malkai Conte 1 COY 7. Age (In yrs. last birthday) If Under Date of Birth g. Birthplace (State or Foreign **Funeral** Months Hours Min (MDry) **Director** 218-20-7923 85 Usual Residence of Decedent 28a-f show 10a State 10b. County 10c. City, Town or Location at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after used in minimum. Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh important: If item 27 is marked other than "natural", or items 2.00 or 28a-f sh important: If item 27 is marked other than "natural", or items 2.00 or 28a-f sh important: If item 27 is marked other than "natural", or items 2.00 or 28a-f sh important in the medical Examiner must be notified at the contract of the Director Bivalve 1 Yes 2 No MD Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21814 3334 Texas Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black White etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Seafood/Farming <u>Waterman</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John W. Dashiell Eliza Cyrus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Madeline Wigfall/Niece 3525 Texas Road, Bivalve, MD 21814 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

Removal from State
4 □ Donation 5 □ Other (Specify) 4-24-2010 Jesterville, MD Elzey UMC Cem Signature of Funeral S 22. Name and Address of Facility 917 W. Isabella St. Bennie Smith Salisbury, MD 21801 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Source Pancreatile disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 48 hr Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): The law requires that the death certificate be executed burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical the for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Veal Pregnant at time of death Day signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď HBP. Rhsumstad attno. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? Yes 2 100 death? certificate 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending

Box 68760 P.O. Records, Hospital or Attending Physician; 24 hours after death. Funeral Director: After this certific Division of Vital completed filled in by the funeral To the P within 2 To the F

Medical Certificate: To Be

	Accident	Investigation		M 1 🗆 Yes 2 🗆 No									
3 ☐ Suicide 4 ☐ Homicide		6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify		ory, office			tion (Street and Number or Rural Route Number, or Town, State)					
ga.	. Certifier 1	Certifying Physicia	an: To the best of my know	ledge, death occured	at the time, date an	id place, ar	nd due to the c	cause(s) and manner as stated.					
								and place, and due to the cause(s) and manner sta	ated				
_	only one) 3 l	Certifying Nurse P	ractioner: To the best of m	y knowledge, death oc	curred at the time, da	ate and plac	ce, and due to t	the cause(s) and manner as stated.					
9 6.	Signature and ti	tle of sertifier	10	2	9c. License number	r		29d. Date signed (Month, Day, Year)					

DZGGIZ

4-17.10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Crouch 105 Pins Bluet. S41 7.

31. Date filed (Month, Day, Year)

32 Registrar's Signatu

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 3 **Physician** Watson S. Dutton, Jr. 2010 1840 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomico Salisbury 338 Delaware Avenue If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 □ F 217-30-9447 4-16-1935 74 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 28a-f show ns 23a or 28a-f shov must be notified at 1 TXYes 2 □ No Director MD Wicomico Salisbury 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be n once. 21801 USA 338 Delaware Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Army If Yes, Give Year or Dates! 963–67 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 M Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No SpecifyBlack Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bus Driver Shore Up! Inc. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florence Wright Watson Dutton, Sr. 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ingrid Dutton-Davis/Daughter 3745 Algonquin Trail, Snow Hill, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State MD Veteran's Cem 4-5-2010 Hurlock, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 917 W. Isabella St. 21 Signature of Fundal Service Licensee Salisbury, MD 21801 Funeral Home Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final Physician 6 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 Type 2 No been signed by the should be detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗀 Inpatient 5 Residence 6 □Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred To the Hosping.

within 24 hours after death.

To the Funeral Director: After a completely filled in by the fur Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760,

State Registrar

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) APR 16

OW

Name and address of person who completed cause of death Item 23a) (Type, Print)



ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 2010 ETHELYN 10:00 /Medical Α. EVANS 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Alice Byrd Tawes Nursing Home Crisfield Somerset If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 🔯 F Director 89 4, 1920 Maryland 218-30-1457 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show s 23a or 28a-f show 1 XYes 2 No Director Crisfield Maryland Somerset 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30 Wynfall Avenue 21817 USA Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. d other than "natural", or items event, the Nedical Examiner or Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married, 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White δ If Yes, Give Ye Ye ar or Dates: Specify: 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene. 27 is marked other than " r traumatic event, the Mark Elementary/Secondary (0-12) College (1-4or 5+) 9 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Noah Evans Rachel Evans 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a 328 Somers Cove Apartments - Crisfield, MD 21817 Ray Evans (Son) item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 □ Cremation 3 □ Ren 4 □ Donation 5 □ Other (Specify) Department of Important: If it any injury or o 3 Removal from State Apr. 15, 2010 Crisfield, Maryland innvridge Memorial Park 21. Signatur 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME 306 W. Main Street - Crisfield, MD 21817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Alzheimer's Disease years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed the burial-transi Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☑ No Day Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐Yes 2 XNo funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Vithin 24 hours after death. To the Funeral Director: Af 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

the 10

Hospital

State Registrar

29a. Certifier (Check only one)

29b. Signature and title of certifier

Atkins, M.D. 201 Hall Highway - Crisfield, Maryland 21817 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D-39813

29d. Date signed (Month, Day, Year)

April 12, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2017PM 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Westminster Carroll 5. Social Securit Public Hospital CALL URGE last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral X** M 2 □ F Months Hours Min 8/30/1950 Director 413-04-8475 28a-f shov 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Yes 2 No MD Carroll Westminster 10 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 300 Church Court 21157 USA items 72 hours after death Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 0 Completed by 1 X Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white "natural", 3 Widowed 4 Divorced Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Program Arc of CC Contract work 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) be f Unknown Emily I. Wright other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 st ment of Health a ant: If item 27 is 4003 Littlestown Pike Westminster, MD 21158 Emily I. Eyler /Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of 1 Burial 2 X Cremation 3 Removal from State Important: If any injury or Carroll Crematory 4/20/2010 Hampstead, MD 4 Donation 5 Other (Specify) Signatu / Funeral Service Lice 22. Name and Address of Facility PA 17340 34 Maple I.Ittlestown 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last onsequence of: Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Records, P.O. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should been Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 🗌 Yes 2 🗌 No Yes Division of Vital director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the only one) 29d. Date signed (Month, Day, Year) MIL ted cause of death (Item 23a) (Type, Print) 30. Name and address of 3 tone? 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Felipe L. Enliquez 10-02535 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ Month Day March 30, 2010 1100 hrs Medical Examiner Felipe L. Enriquez 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 2200 Ednor Road Silver Spring Montgomery 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Country) Months Days Hours Director 1 X M 2 F 25 02/05/1985 Guatemala None Usual Residence of Decedent 10d. Inside City Limits ij 10a. State 10c. City, Town or Location 10b. County 1 Yes 2 No Washington D.C. permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho rigins or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1251 5th. St. NW 20011 Guatemala 14. Race - American Indian, Black, Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2 X No Yes 1 X Yes 2 No specify: Guatemala Hispanic 3 Widowed 4 Divorced If Yes, Give Year Specify: \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Construction 9th. Labor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Maria Elisa Enriquez Ramos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1251 5th. St. NW Wash. D.C. 20011 Victoria Inai Mendez/Friend 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 X Removal from State crematory or other place) 04/29/10 Guatemala General Cemetery 4 Donation 5 Other Specify. 21. Signature of Funeral Service Ligensee 2. Name and Address of Facility John T. Rhines Funeral Home 3005 12th. St. NE Wash. D.C. 20017 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death a. Multiple Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Physician/Medical AMENDED UNPENDED attending physician for use as the burial Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 Live birth 3 Ectopic pregnancy Fetal death Month Day Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) æ examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: A Nursing Home 5 Residence 6 Other: Scene this 1 🗸 Yes 2 No After 28a. Date of Injury FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject shot 1 Natural FOUND: 1 Yes 2 ✔ No Pending Director: in by the f Mar 31, 2010 1046 hrs Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) 2200 Ednor Road, Silver Spring, MD filled determined (Specify) Woods 4 V Homicide 29a. Certifier 1 To the Function Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier April 1, 2010 O.C.M.E. Cortecul ne and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day Year) 2010 2. Registrar's Signature arted State

DHMH 17 Rev 1/2001 OCMF 2006

Registrar

5 26 A-B

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician Stephanie Louise Fake 10:40 AM April 20 2010 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 2597 Manchester Rd. Westminster Carroll If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 1 F Director 197-34-2366 65 09/25/1944 Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its invided Examination once. 1 ☐ Yes 2 ☑ No Director Maryland Carroll Westminster 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2597 Manchester Rd. 21157 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Maryland 21215-0036 1 ☐ Yes 2 ➡No Specify: ò 3 ☐ Widowed 4 🔀 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Mohr, Sr. Eleanor Spangler ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thane J. Fake/Son 2597 Manchester Rd., Westminster, MD 21157 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Carroll Cremation Inc 04/21/2010 Hampstead, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Pritts Funeral Home and Chapel, P.A. 412 Washington Rd., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** cerebro vascula disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical attending p for use as t IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year ☐ Pregnant at time of death 5 Other (specify) P.O. 9 D Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has autopsy Hospital or Attending Physician: The certificate 1∐Yes 2DXNo director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this After thi 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Aatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated.

Division of Vital Records, within 24 hours after death.

To the Funeral Director: A

Completely filled in by the fu To the within 2 5

Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) 04-22-2010

Westminster,

censiliya, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. PANSURIYA

Malco

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 19 ay Physician/ 2010 Year 8:03 pm Tekie Fessehatzion Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Towson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Months Days Hours 08/20/1943 Country) Eritrea Director 528-72-5064 66 Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Howard Columbia 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 11804 New Country Lane 21044 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 🗶 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: "natural" Specify: 3 Widowed 4 X Divorced Black permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Professor Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fessehatzion Wodemichael Letekidan Ghebru 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kahsay Fessehatzion - Brother 11804 New Country Lane, Columbia, Maryland 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 K Removal from State 4 Donation 5 Other (Speqify) Asmara Cemetery 04/27/2010 |Asmara, Eritrea 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home. 11800 New Hampshire Ave., Silver Spring, MD 20<u>904</u> 23a. I art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he t f ilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MCMANIC disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗖 Unknown this certificate has been siral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed? Yes 2 No death? 2 🗌 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined

Division of Vital Records, P.O. Box 68760 ne Hospital or Attending Pt n 24 hours after death. ne Funeral Director; After th To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completed filled in by the fu

State

Medical

(Check only one)

29b. Signature and title of contifier

Grant

Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701

Charles

N.

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

auson.

2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

R149194

29d. Date signed (Month. Dav. Year)

April 20, 2010

29c. License number

Physician. Medica **Examine** Funeral Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036

Physician/ Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

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,	State Registrar					Ce	rtificate of	Death	7		Reg. I	No.	0.1	0 11	O.F
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er	4a. Facility Name (if						4b. City, Town,			4c. County					
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ed	3 🗌 Widowed	4 Divorced	4	If Yes, Give Year or Dates.			1 ☐ Yes 2X N	lo Speci	ify:			Specify	Bla	ack	
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_		Joshua E. Miles Evelyn A. Whittington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State													
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	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cernetery, crematory or other place) 20c. Location - City of cernetery, crematory or other place)														
	21, Signature of Foneral Service Licensee 22, Name and Address of Facility 917 W Tsahella													_	
Bennie Smith Funeral Home Salisbury, MD 2180															
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	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition CEREBOUVASCULA? ACCIDENT											Interval Betwood Onset and De			
	disease or condition resulting in death) Due to (or as a consequence of):														
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To Be Completed by Physician/Medical	1 ☐ Yes 2 ☐ 9 ☐ Unknown			9 Unknown			_ 0 (0,000.))					_			
y PI	Part II. Other signifi	icant condition	ons con	tributing to death b	ut not res	ulting in the u	underlying cause	given in Pa	art 1.	23e. Did t	obacc	o use cont	tribute to	the cause of dea	ath?
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70 E	examiner?	No	H	ospital: 1	ent 2 🗆	ER/Outpatie	nt 3 🗆 DOA	ther: 4	Nursing Ho	me 5 🗌 Resi	dence	6 🗆 Oth	er (Spec	cify)	
ite:	27. Manner of Death	5 🗌 Pendir	20	28a. Date of injui		28b. Time of injury				28d. Describe					
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Sert	4 Homicide	determ		28e. Place of Injubulding, etc	ry - At ho . (Specify,	me, farm, str)	eet, factory, office			28f. Location (City or Tox			er or Ru	ıral Route Numbe.	r,
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Medical Certificate:	(Check 2	Medical E	Examine	cian: To the best of er: On the basis of e Practioner: To the	kamination	and/or inves	tigation, in my opi	nion, death	occurred a	the time, date	and pla	ce, <i>a</i> nd du	e to the	cause(s) and mann	ner stated.
Σ	29b. Signature and t			1-0		Knowledge,	29c. Licen	se numbe	r		29d. [Date signe	d (Mont	h, Day, Year)	
			04	type mi)		Do	062	172		4	1191	120	10	
				mpleted cause of de	eath (Item	23a) (Type, I	Print)								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sin ARAO R SATYAL, MD 1604 MARKET ST POLOMOKE CITY MD 21851.															

State Registrar

31. Date filed (Month, APR) 2 2 2010 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item 26 per phys. G904 6/22/10 dk
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2010 Physician 51AWB3 SONN NNEC /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death City, Town, or Location of Death **Examiner** Somer ANIOC 24 Hrs. 8. Date DY Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Min. Days Months Hours 220-26-340 Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits show Department of Health and Mental Hyglene. Important; If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evan that the rottling any once. 1 ☐ Yes 2 🔼 No Director Somerset Maryland 10e. Street and Number Westover 10g. Citizen of What Country? 10f. Zip Code 31264 Charles 21871 Barnes Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Elyes 2 No If Yes, Give Year or Dates: 1943 -45 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: \$ Specify: Black 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Farming Ludistr 7th grade Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clara Smith Finney ပ္ John 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rouse -Daughter 30380 Apt 209 Princess Anne, Md 21853 Maple 5+ Diane 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hurlock, md 4/26/10 MD vetering Cemetry permit. 22. Name and Add ss of Facility 21. Signature of Funeral Service Licensee Anthony E. Ward F. H. Ave Princess Anna, Md 21853 30639 Hampden 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** KT6STAIL /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Day to (or as a consequence of) requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician the for use as the buria Physician/Medical IF FEMALE: .To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 100 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform 1 □Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) daughter's 6 MOther (Specify) residence Other: 4 \sum Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director; After 1 Matural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide GertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner st 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) HI . Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death ent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Gunther Month Physician/ Year (O tun 1651 osessa Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Hospital Center Westminster Carroll . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year) 940 1 M M 2 🗆 F Months Days Hours (Month, Day, Sep 28 Mary land 69 217-38-3658 Director Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location within 72 hours after death with the Maryland Director r 28a-f sl notified Taneytown Maryland Carroll 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe ns 23a r cmust h Funeral 21787 104 Ponytail Lane USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Bace - American Indian Examiner Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white "natural" 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working State of life. DO NOT use retired) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Maryland CPA/Business Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Eva Kropkowski Joseph Guntner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 Ponytail Lane, Taneytown, MD 21787 Rosemary E. Guntner, wife permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4/23/2010 Tanevtown, MD 4 ☐ Donation 5 ☐ Other (Specify) St. Joseph Catholic , Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home Baltimore St, Taneytown, MD 21787 a 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Preun on in Physician/ In disease or condition Medical resulting in death) Examiner discesse Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been simpled to the continue of the continue Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death ed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes 2 No 3 Probably 4 nknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? performed' 2 -No 1 🗌 Yes 2 1 N Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to predical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 No Other: မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work' 1 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3

State Registrar

31. Date filed (Month, Dav. Year.

me and address of person who completed cause of death (Item 23a) (Type, Print)

32.

Degistrar's Signature

			State of Maryland / Department of He		ental Hygien	е		
	-6. Yo	_	1 - State Registrar Certificate of D 1. Decedent's Name (First, Middle, Last)		Reg. No 2. Date of Death	2010	3. Time of Death	
	Physicia	an			Month Day Year April 20, 2010 2:20 P M			
	/Medic Examin		PATSY LEE HINMAN 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or		4c. County of Death			
	LAGIIIII	ei		risfield		Somerse	t	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Months Days	Hours Min.	3. Date of Birth (Month, Day, Year	r) Co	nplace (State or Foreign untry)	
* *	Director		214-28-8589 TDM 2KDF 77 Yrs. Usual Residence of Decedent	l l	May 17, 19	932 Mai	ryland	
	/land ow		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits	
	a-f sh	ctor	Maryland Somerset Crisfield				1 X Yes 2 □ No	
	ith the)ire	10e. Street and Number 10f. Zip Code	11017	10g. C	itizen of What Co	-	
	2 should be filed within 72 hours after death with the Maryland and Menhal Highen. Is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 25a or 28a-f show aumatic event, the Medical Examiner must be notified at	Funeral Director		21817		U.S.A		
	ter de items iner n	-une	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No	n, Mexican, Puerto R	ican, etc.)	Black, White		
936	urs af al", or xami	by	If Yes, Give 1 ☐ Yes 2 ☑ No Year or Dates:	Specify:		Specify: Wh	ite	
21215-0036	72 hor	Completed	15. Decedent's Education 16a. Decedent's Usual Occupa (Specify only highest grade completed) (Give kind of work done di	ition Jurina most of working	16b. I	Kind of Business/	Industry	
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22	iled w Hygie ther tl		10 Waltiess 17. Father's Name (First, Middle, Last)	18. Mother's Name (.L	
auc	d d d d	To Be	George Henry Blake	Nina M	ae Ward	,		
Maryland	should and Men s marke umatic	ř	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street a	and Number or Rural	Route Number, City	or Town, State, Z	Zip Code)	
	s 1 and 2 should of Health and Men item 27 is marke other traumatic		George Lindsey Blevins (Son) 17708 Toakoana					
ltimore,			20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)			Location - City or		
Ē	: Pag tπent tant: jury o		4 □ Donation 5 □ Other (Specify) Sunnyricge Memorial Pa			isfield,	MD	
Ba	permit. Page Department of Important: If any injury or once.		21. Signature Mery Service Licensee Bradshaw & 306 W. Mai				17	
	*		23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line.	g, such as cardiac or	respiratory arrest,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	ANT 1	Brluse		Onset and Death	
	/Medical Examiner		resulting in death) Due to (or as a cons-qu nce of):			-		
3		e.	Sequentially list conditions, Due to (or as a consequence of):			9		
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					
o,	e exec an an irial-tr		resulting in death) Last Due to (or as a consequence of):					
8760,	cate be executed physician and the burial-transit	dical	d					
ဖ	sertific ding p	/Mec	IF FEMALE: 23c. If yes, outcome pf pregnancy	100		Old Date of de	livon	
Вох	The law requires that the death certific te has been signed by the attending p age 2 should be detached for use as	Physician/Me	in the past 12 menths?			23d. Date of del Month	Day Year	
o.	w requires that the de been signed by the s should be detached	hysi	1 Yes 2 No 9 Unknown					
Records, P.O	s that jned b	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	n in Part I.	23e. Did tobacco	use contribute to	the cause of death?	
ord	equire sen siç ould b				1 Tes	2 No 3 Pr	robably 4 □Unknown	
ec	has be ge 2 sh	Completed			24a. Was an autopsy	prior to	utopsy findings available completion of cause of	
_		Con			performed? 1□ Yes 2□1		2 No	
Vital	slcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other	26. Place of Death		0 000 (0		
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Ö	ath. ath. ir: Aft	atio	2 ☐ Accident investigation M 1 ☐ \	Yes 2 □ No				
Division or	or Attendation death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	21	8f. Location (Street and City or Town, Sta	and Number or Ra ate)	ural Route Number,	
_	ospital hours a uneral I		29a. Certifier (Check only (Ch					
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical	29b. Signature and title of certifier 29c. License			Date signed (Mont		
ý	N P SS		D-	39813		4/21	110	
	2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. A. W. 20, Usell 11. 31. Date filed (Month, Day, Year) APR 23 2010 Leven A. January APR 23 2010	ighway (Phis rela	20 1m	2(81)	
Ţ	Sta Registi		31. Date filed (Month, Day, Year) APR 2 3 2010 32. Registrar's Signature APR 2 3 2010			S. P.		

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician Jeanette Ann Hemming 2010 28 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's St. Mary's Hospital Leonardtown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2√2 F Director 59 1950 Maryland 217-68-6348 Dec, 13, Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show 1 ☐ Yes 2X No Directo Maryland St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 44421 Clarkes Landing Road 20636 Funeral USA Department of Health and Mental Hygiens, it involves are used important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examination once. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 X Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No <u>م</u> Specify. Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry John Hemming Mary Alice Ferguson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Hemming Gotwald Sister 310 Woodland Terrace Alexandria, VA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State St. John's Cemetery May 4, 2010 Hollywood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service P.O. Box 270 Leonardtown, MD 20650 23a. Part I. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Deat Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner Die to for es a consecuence of: certificate be executed use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, physician Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 mop Month Day Year 5 ☐ Other (specify) P.O. ed by the detached to ☐Yes 2 No 9 Unknown 9 Unknown signed by the betach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Completed 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate 1 □Yes 2 1 Yes Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 1 Npatient 2 ER/Outpatient 3 DOA After this Certification: To funeral 27 Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 atural 5 ☐ Pending investigation death. s after death 2 Accident 1 ☐ Yes 2 ☐ No filled in by the 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 34198 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David M. Federle, M.D. 24035 Three Notch Rd. Hollywood, MD 20636 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Medical Examiner Scott Fliott Highsmith 4a. Facility Name (if not institution, give street and number) Carroll Hospital Center Funeral Director Scott Fliott Highsmith 4b. City, Town, or Location of Death Westminister Westminister 6. Sex 7. Age (In yrs. last birthday) 1	Dd. Inside City Limits Yes 2 X No
Medical Examiner Scott Eliott Highsmith 4a. Facility Name (if not institution, give street and number) Carroll Hospital Center 5. Social Security Number 213-68-4614 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Ab. City, Town, or Location of Death Westminister Westminister 4b. City, Town, or Location of Death Westminister 4c. County of Death Carroll 4c. County of Death Carroll 4c. County of Death Carroll 4d. City, Town, or Location of Death Carroll 4c. County of Death Carroll 4d. County of Death Carroll 4d. City, Town, or Location of Death Carroll 4d. County of Deat	lace (State or ry) MD Od. Inside City Limits Yes 2 X No
4a. Facility Name (if not institution, give street and number) Carroll Hospital Center 4b. City, Town, or Location of Death Westminister Westminister 5. Social Security Number 213-68-4614 Usual Residence of Decedent 10a. State 10b. County 4c. County of Death Westminister 4c. County of Death Carroll 4d. County of Death Westminister 4c. County of Death Carroll 4d. C	Dd. Inside City Limits Yes 2 X No
Funeral Director 5. Social Security Number 213-68-4614 1	Dd. Inside City Limits Yes 2 X No
Director 213-68-4614 1 M 2 F 42 Yrs. Months Days Hours Min. Aug 6, 1967 Foreign Country Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	Dd. Inside City Limits Yes 2 X No
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d	Yes 2 X No
₹	Yes 2 X No
The street and Number 10f. Zip Code 10g. Citizen of What Country?	
	n Indian, 8lack,
(a) (b) (c) (d) (d) (d) (d) (d) (d) (d) (d) (d) (d	n Indian, 8lack,
11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American I If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 15. White, etc.	
Write, etc. The state of the	-A
The state of Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	
15. Decedent's Education (Speciny only highest grade completed) Solution Fig. 19	
Construction Home Improver 12 Construction 18. Mother's Name (First, Middle, Maiden Surname)	ement
Raymond Carl Highsmith, Jr. Raymond Carl Highsmith, Jr. V. Elise Buchanan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip	
To go	
V. Elise Highsmith Mother 1826 Dennings Rd. New Windsor, MD 21776 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town	
20. Place of Disposition (Name of Certificity) 1	Maryland
4 Donation 5 Other Specify: Carroll Cremation Inc 4/20/2010 Hampstead, Inc. 21 Signature of Funeral Service Licensee 22. Name and Address of Facility Pritts Funeral Home & Cremation Inc. 22. Name and Address of Facility Pritts Funeral Home & Cremation Inc. 24/20/2010 Hampstead, Inc. 22. Name and Address of Facility Pritts Funeral Home & Cremation Inc. 24/20/2010 Hampstead, Inc. 24/20/2010 Hampste	
1412 Washington Rd. Westminster, MD 2.	21157 Approximate Interval
/Medical failure. List only one cause on each line.	8etween Onset and Death
Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	
Sequentially list conditions, b	
cause. Enter Underlying Cause	
events resulting in death) Last Due to (or as a consequence of): d.	
% a d UNPENDED I AMENDED	
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past 12 months? The Even India of death of the pregnant at time of the preg	
On so state of the contribute to the contribute	cause of death?
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the contribution of the contrib	ly 4 Unknown
24a. Was an autopsy prior to compi	sy findings available pletion of cause of
24a. Was an autopsy prior to compi death? 1 ✓ Yes 2 No 1 ✓ Yes	2 No
y e grad of the special of the spec	
The spiral of th	
O se de determined of Death 20 determined	collision
Very state of the	
4 Homicide determined (Specify) Major Road / Highway Bowersox Road & Nicodemus Road, No. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	New Windsor, Md.
Homicide A Homicide A Homicide A Homicide A Homicide A Homicide A Homicide A Homicide A Homicide A Homicide A A Homicide A A A A A A A A A	ause(s)
29d. Date signed (Month, L	Day, Year)
James Journall, M) O.C.M.E. April 18, 2010	
30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar	

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 **Physician** Helen Elizabeth Heltibridle 18, 7:20 p April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Lorien Nursing & Rehabilitation Ctr Taneytown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months 1 □ M 2 🕱 F Davs Hours 86 June 5, 1923 Pennsylvania Director 196–18–5010 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits f show mit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla warfment of Health and Mental Hygiene. The treath and Mental Hygiene and cortant: If Item 23 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, I in "succel Exeminar must be notified at injury or other traumatic event, I in "succel Exeminar must be notified at 1 ☐ Yes 2 No Director Carroll Taneytown Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3960 Baptist Road 21787 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 9 Specify: white 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nursing Assistant Hospital 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Arthur N. Starner Bertha A. Shorb ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other trau <u>once.</u> Daniel T. Heltibridle, son 3960 Baptist Road, Taneytown, MD 21787 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Keysville Union Cem 4/22/2010 Keysville, MD 22. Name and Address of Facility Signature of Funeral Service Lineasee Myers-Durboraw Funeral Home 136 E Baltimore St, Taneytown, MD 21787 29a Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. pproximate Between nd Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical e to (one s a consequenc Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate 1 □Yes Hospital or Attending Physician; 124 hours after death.
Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2**Z**No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours a To the Funeral C 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed Month, Day, Year) 30. Name a d address of person who

Registrar DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Pay 2010 Physician/ Houlihan A Ponth Ward Charles Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner shing ton Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 5. Social Security Numbe 578-30-0220 Months Days Hours Oct 11, Pay, Year 926 Vifrgihia 83 Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 1 ☐ Yes 2 No Beltsville Maryland Prince George's 10f. Zip Code 20705 10e. Street and Number 10g. Citizen of What Country?
United States Funeral 3910 Howard Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 1 Never Married 2 Married 1 Yes 219/19-1946 If Yes, Give 1947-1952 Year or Date 1947-1952 þ permit, Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examians injury or other traumatic event, the Medical Examia 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Owner and Operator Kitchen Installers Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rita Margaret Varner Charles Pinkney Houlihan 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3910 Howard Road Beltsville, Maryland 20705 Elizabeth Lambert -wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Metropolitan Crematory 4/20/2010 Alexandria, Virginia 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Bonala V. Borgwardt Funeral Home, PA med 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. OBCRUCINE FULMONARY O CASE and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day Pregnant at time of death Yes 2 ☐ No 9 Unknown the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 4 🗹 Unknown 1 🗌 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has be autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 🖪 No Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Natural Accident Investigation 6 Could not be 3 Suicide 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Date signed (Month, Day, Year) 29b. Signature and tive of certifier

State Registrar and address of person who comp

1ABAH

31. Date filed (Month, Day, Year)

Glen Burnie Mid

epod cause of death (Item 23a) (Type, Print)

Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2010 Clinton Albert Hartley April 9:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Hagerstown Golden Living Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 X M 2 □ F 215-34-2552 74 Director 06/06/1935 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show adical Examiner must be notified at 1 √ Yes 2 No Director MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with thygiene. 750 Dual Highway 21740 US Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🗓 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed item 27 Is marked other than "natur other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry $\overset{\text{Elementary/Secondary}}{12}^{\text{(0-12)}}$ College (1-4or 5+) Highway Inspector County Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fil Health and Mental H tem 27 Is marked ott Be Clarence Cross Hartley Ora Nancy Whitfield 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darla M. Hartley / Wife 320 Key West Drive, Hagerstown, MD 21740 If item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Injury or permit. Page Department o Important: If any Injury or Piney Plains Cemety. April 29,2010 | Little Orleans, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service Licens 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** nichemo 4 moults disease or condition resulting in death) /Medical Due to (or s a cons quence of): **Examiner** Cerebiovoscillon Sequentially list conditions, if any, leading to minipulate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner certificate be executed burial-transi and resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. attending physician Physician/Medical as the IF FEMALE: use yes, outcome pf pregnancy
☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 □Ectopic pregnancy for Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 s has autopsy performed?

1 Yes 2 2 No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No completely filled in by the 3 Suicide 6 Could not be determined Płace of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 128361 4-2570

3H. L+1

State Registrar 131. Date filed (Month, Day, Year)

APR 26 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

i 368 null Styce 2. Rigistrar's Signature Hapstern 170 21740

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day APRTL 2018 Physician/ 7:20 PM HOHMEIER 20 GEORGE J. Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** WORCESTER BERLIN BERLIN NURSING & REHABILITATION CTR. 8. Date of Birth (Month, Day, Year) APRIL 27 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Min. 1 🕅 M 2 □ F Months ILLINOIS 86 **Director** 324-18-6553 Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "--- any injury or other than "---10c. City. Town or Location 10a. State 10b. County Director 1 X Yes 2 No DELAWARE SUSSEX FENWICK ISLAND 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral 19944 USA 1208 COASTAL HWY. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married δ 1 ☐ Yes 2 🖾 No Specify: Specify: WHITE 3 X Widowed 4 Divorced Completed Year or Dates. 1942-45 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) BUSINESS EQUIPMENT MAINTENANCE MECHANIC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည HOHMETER KATHERINE KULLECK JOSEPH L. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1208 COASTAL HWY., FENWICK ISLAND, DE. 19944 AMY M. VICKERS/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State 4/24/10 ROXANA, DELAWARE ROXANA CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Lic HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): n any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has have also a second of the funeral Director. the attending physician and thed for use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Year 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 No 26. Place of Death (Check only one) completed filled in by the funeral director, 25. Was case referred to medical Be examiner? Hospital: Other: 1 Yes 2 **X**Vo 1 Inpatient 2 ER/Outpatient 3 DOA 4 XNursing Home 5 Residence 6 Other (Specify) Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at work? injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Under the cause (s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier April 21, 2010 enme 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Pennie

Date filed (Month)

Savage,

CRNP

32. Registrar's Signature

GEORGE

HOHMEIER,

9715 Healthway Dr, Berlin,

MD

			For State Registrar		State of Ma	ryland		rtment of I tificate of I			,	giene Reg. No	001	7	11.261
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	Examin	er	4a. Facility Name (if not institution, give street and number)					4b. City, Town, c	r Location	n of Death			. County of Dea	ath	
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Baltimore,	permit. Page 1 a Department of F Important: If ite any injury or ot	М	20a. Method of Disp 1 🖾 Burial 2	☐ Cremation 3 ☐	Removal from State	cem	etery, crem	ition (Name of atory or other plac		Da	- 1		ocation - City o		
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Division of Vital Records, P.O.	or Attending Physician: The law requires that the death certif fifer death. Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use a	Completed by Physician/M	ran ii. Other signin	cant conditions co	ontributing to death but	not resultii	ng in the un	denying cause gr	ven in Pan	τι.			use contribute to		use of death? 4 Donknown
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 5 Charlotte 1258 TM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🛛 F Min. Ma (Mo 29 9 Day, 1924 85 Penngylvania 215-20-9342 Director Yrs. Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ant: If item 27 is marked other than "natural", or items be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director items 23a or 28a-f s her must be notified Maryland Washington Hagerstown 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12345 Walnut Point West 21740 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White 3 Widowed 4 Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 27 is marked other than it traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Roy McKinley Robinson Charlotte Mae 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Albert H. Hamby Husband 12345 Walnut Point West, Hagerstown, Md. 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 X Burial 2 Cremation 3 Removal from State Broadfording Cemetery | 05-07-10 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 21. Signature of Funeral Service Licenses ালে মালিক পা পালিকের প্রিক্তি বিশ্বাসন Armeral Home, Inc. R. hoel Bra 40 East Antietam Street, Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Priysician OPTIC HOCK disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** CLOSTRIDIUM DIFFICHLE Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Examine Due to for sela noneaguence of: been signed by the attending physician and should be detached for use as the burial-transit law requires that the death certificate be executed Cause (Disease or linjury URINWAY TRACT that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical ABETES Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Dav Year 1 Yes 24 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 • Hospital or Attending Physician: The L24 hours after death.
• Funeral Director: After this certificate heled filled in by the funeral director, page performed 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 X No Other: 2 1 Tes 1 Nation 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural (Month, Day, Year) injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number completed filled in by determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deadle occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifie

DHMH 17 Rev 7/2009

State Registrar 251

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WIRSON

32. Registrar's Signature

121

31. Date filed (Month, Day, Year)

10062006

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HALI GUITONIN MY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Jerry Lee Hottle . 201<u>0</u> Physician/ April 30 12:55 A.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 165 W. Washington St. Apt 200 Washington Hagerstown 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 16,1958 9. Birthplace (State or Foreign **Funeral** 1 **x** M 2 □ F Days Hours 219-46-3722 52 Vrs Maryland Director Nov. Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington 1 XYes 2 No Hagerstown 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral death with 165 W. Washington St. Apt 200 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 2 1 Never Married 2 Married Yes 2X No Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 ☐ No Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar Specify 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 in and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Machinist Tannery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Clearence Sammuel Hottle Mildred Louise Wetzel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17933 Lappans Rd. Fairplay, Maryland 21733 David Hottle (Brother) 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State May 4, Smithsburg, Maryland Smithsburg Crematory 4 Donation 5 Other (Specify) 2010 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J.L. Davis Funeral Home MO 1414 12525 Bradbury Ave. Smithsburg, Maryland 21783 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) arcinoma Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): and -transit Exam or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burial-1 ng physician as the burial Physician/Medical Records, P.O. Box 68760 attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Day ned by the a g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed Yes 2 Diaps certificate Division of Vital 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Hospital: 1 🗆 Yes 2 🖳 No Other ျာ 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ this 27. Manner Death hours after death.

neral Director: After the filled in by the funeral Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 Tes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours at To the Funeral D Completed filled in Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the only on Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu 29d. Date signed (Month, Day, Year) DOOS 7285 MD 30. Name and ad ho completed cause of death (Item 23a) (Type, Print) N 31. Date filed (Month, Day, Year) 32. Reistrar's Signature State

Registrar

	Day Year 2010 W: 32 AM 4c. County of Death
As. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	4c. County of Death 4c. County of Death 4c. County of Death 9. Birthplace (State or Foreign Country) 7FANSYLVANEA 10d. Inside City Limits
The Johns Hopkins Hospital The Johns Hopkins Hospital 5. Social Security Number 1	29, 1937 PENUSYLVAUEA 10d. Inside City Limits
Director 204-28-0105 1 M 2 F 72 Yrs. Months Days Hours Min. (Month My) Usual Residence of Decedent	29, 1937 PENUSYLVAUEA 10d. Inside City Limits
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\$ 88 200 MEANS HOLLOW RD. 17257	10g. Citizen of What Country?
	U.S.A
The second secon	14. Race - American Indian, Black, White, etc. Specify: WNZTE
The second of th	16b. Kind of Business/Industry
The secondary (0-12) College (1-4 or 5+) HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, M	OWN HOME
BLAIN WYRICK AMA KA	DEEMAN
The property of the part of th	umber, City or Town, State, Zip Code)
LISA SUDERS / DAUGHTER 402 McCULLOCH RD. SHIPPI	NSBURG PA 17257
20a. Method of Disposition 1 Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 3 Name and Address of Facility 21. Signature of Funeral Service Licensee 22. Name and Address of Facility	20c. Location - City or Town, State
	- BRENCER FUNERAL HOME , DVC.
1 #/(0/346 SIRPONS	ST PO RCH 336
23a. Part 1. Enter the disease, or complifations that caused the death. Do not enter the mode of dying, such as cardiac or respirate shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Dut (or as a consequence of):	ory arrest, Approximate Interval Between Onset and Death
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La Records, and the last has been signed by the last has b	autopsy prior to completion of cause of death?
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25. Was case referred to medical examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check of Death	Residence 6 Other (Specify)
27. Manner of Death 28d. Date of Injury 48d. Desc 28d. Desc 28d. Desc 28d. Date of Injury 48d. Desc 48d. Des	ibe how injury occurred
The state of the s	on (Street and Number or Rural Route Number, Town, State)
29a. Certifier (check only one)	
at in the part of	29d. Date signed (Month, Day, Year)
S. ME MD RES-000	April 28, 2010
30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Wolfe St, Baltimore, MD, 21287

Registrar

			for State	State of Mary		epartment of F Certificate of			_	0.00	
			Registrar 1. Decedent's Name (First, Middle,	Last)		or imodic or	Douin	2. Date of De		2010	3. Time of Death
	Physic /Med		Herbert Walter	Jorgensen				Month 4	20 ^{Day}	20 ใช้	1:25 P M
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	and	7	Usual Residence of Decedent 10a, State 10b, County	10	c. City, Town o	r Location				10	Od. Inside City Limits
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	h the	Director	10e. Street and Number	S.M.C. y		10f. Zip Code			10g. Citize	en of What Coun	try?
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	er de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married	12. Was Decedent Ever Armed Forces? 1 XYes 2 No	in U.S.	 Was Decedent of F If Yes, specify Cub. 	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14	 Race - Americ Black, White, e 	
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3	Of VITAI Physician: T rthis certificat ral director, pe	Be	25. Was case referred to medical examiner?	Hospital:		100	26. Place of Death	(Check only o	ne)		
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	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check only one)	Physician: To the best of my aminer: On the basis of exa and manner stated.	mination and/o	or investigation, in my o	me, date and place, opinion, death occurr	ed at the time,	date and p	and manner as si place, and due to	the cause(s)
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4			MAI	M.D.		D 00	64120		41	20/201	10.
	21/11		A IV K	o completed cause of death	(Item 23a) (Ty	pe, Print)	D	1	111		
Ĭ	1+3 MG	te.	Attit Zeeshou 31. Date filed (Month, Day, Year)	7 AGH 9733 32. Registrar's S	H Calt Bignature	hway Dr	ve Ber	11"4	(IV)	2181	1:
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Sr. Physician/ O POHC Medical 4a. Facility Name (if not institution, give street and number)

A V. H Charlotte Hall Veterans 4b. City, Town, or Location of Death 4c. County of Death Examiner GHARLOTTE MAG Home 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8, Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1 ፟፟ M 2 □ F Months Days 84 Yrs. 220-16-8135 Director March 3, Maryland Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ems 23a or 28a-f sh r must be notified a Maryland Charlotte Hall Charles 1 Yes 2 No 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 12446 Whisper Creek Court 20622 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ŏ δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White "natural" Completed 3 X Widowed 4 Divorced Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Master Plumber Plumbing 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Page 1 and 2 should be filer tment of Health and Mental F tant: If item 27 is marked of ၉ Catherine Connelly Ignatius Jackson Jarboe Marv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12446 Whisper Creek Court, Charlotte Hall, MD 20622 John Leonard Jarboe, Jr. / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 🔀 Burial 2 🗌 Cremation 3 🗍 Removal from State St. Aloysius Catholic Church Cemetery April 29, 2010 Leonardtown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. Jardener P.O. Box 270, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final ARRHYTHMIA Physician/ disease or condition resulting in death) ARDIAC Medical Due to (or as a consequence of) Examiner DISEASE ORONARY ARTERY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): physician and the burial-transit HYPERTENSION ESSENTIAL that initiated events resulting in death) Last Due to (or as a consequence of). attending physician Physician/Medical Box 68760 as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year signed by the a d be detached for g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ DISEASE ALZAEIMER'S Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of has performed? death? 1 ☐ Yes 2 ☐ No Yes 2 No Division of Vital completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide Hospital or Attending 5 Pending death, 1 ☐ Yes 2 ☐ No Investigation Director; 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined hours after City or Town, State 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0067788 turce MD 4.26.2010 2 Rme 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29449 Charlotte Hall Road, Charlotte Hall, MD 20622 RAO KODALI, MD,

DHMH 17 Rev 7/2009

State Registrar LEENA

31, Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Caton Kandrashoff 2010 450M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death If Unde If Under 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland 1 □ M 2 🗓 F Months Days Hours (Month, Day, Year) 8-21-1944 220-42-9625 65 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🏋 No MD Wicomico Delmar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 29588 Stillwood Drive 21875 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 X Married ☐ Yes 2 X No If Yes, Give 1 ☐ Yes 2 🔀 No Specify: White 3 Widowed 4 Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Office Manager Dental Office Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Stuart Ilene Caton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eric Kandrashoff - Husband 29588 Stillwood Drive, Delmar, Maryland 21875 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Durial 2 X Cremation 3 D Removal from State 4 ☐ Donation 5 ☐ Other (Specify) rematory of Delmarva 4-22-2010 Delmar, Delaware 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bounds Funeral Home Kelle 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ach line Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 2 🗌 No 4 ☐ Pregnant 9 ☐ Unknown 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death rtificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending iniury

law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Division of Vital Records, P.O. Box 68760 After t r death.

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/

⁴Examiner

Medical

Baltimore, Maryland 21215-0036

6 State

tal or Att rs after d al Direct ed in by	I Cert	4 Homicide determined	28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	actory, office		Street and Number or Rural Route Number, wn, State)
the Hospite hin 24 hours the Funeral npleted fille	Medica	(Check 2 L Medical Examine	ian: To the best of my knowledge, death occur r: On the basis of examination and/or investigatic Practioner: To the best of my knowledge, death	on, in my opinion, death occurred a	at the time, date	and place, and due to the cause(s) and manner stated
With With CONT		29b. Signature and title of certifier	, 1	29c. License number		29d. Date signed (Month, Day, Year)
5		1 Valor		D34768		April 19, 2010
ml.		30. Name and address of person who con	npleted cause of death (Item 23a) (Type, Print)			

1 Tes 2 No

Accident

Suicide

Investigation 6 Could not be

Ruy M. WiElAND MD 100 & CARROLL St. SAlisbury md 21801

Registrar

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 19^{Day} 201^Y0 Month 3:30P M Physician/ Barbara Ann Locke Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Frederick **Examiner** Mt. Airy Kline Hospice House 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday 5. Social Security Number MD Days Hours 7 / 2.3 / 1 9 4 9 Months Funeral 1 □ M 2**X** F 60 212-50-8035 Director 10d. Inside City Limits 10c. City, Town or Location ıral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State should be filed within 72 hours after death with the Maryland **Funeral Director** 1 X Yes 2 No Frederick Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21702 2003 Chapel Ct. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black White, etc. 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates. à 1 Never Married 2XX Married Specify: 1 Yes 2X No Specify: White Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical! 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) own home homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Viola Brashears Robert W. Grabill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $2003~{
m Chapel~Ct.,}~{
m Frederick,}~{
m MD}~21702$ 19a, Informant's Name/Relationship (Type, Print) Michael Locke (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition or other place) Reformed Cemetery 4/23/201 Middletown, 1 ☑ Buria 2 ☐ Cremation 1 ☐ Removal from State 4 ☐ Sonation 5 ☐ Other (Specify) Bonald ddress of Family ompson Funeral Home 21 Signature POB 18, Middletown, MD or complicity is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, it only one of se on each line. Approximate Interval Between Onset and Death nter the diseas or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death) melanoma Physician/ Due to (or as a consequence of): Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last signed by the attending physician d be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Year Month in the past 12 months?

1 Yes 2 XNo Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Linknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☒ Unknown <u>۾</u> 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed has Yes To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate 26. Place of Death (Check only one) HOSPICE 25. Was case referred to medical examiner? Be funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) House Hospital ER/Outpatient 3 DOA 2 1 No 1 Inpatient 2 မြ 1 Tyes 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 27. Manner of Death work? 1 🖪 Natural 5 Pending Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide determined completed filled in by 4 Homicide 1 @ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 4-21-10 70067691 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FLEDELICK, MD. 2170 716 GOLDSFEIN 32. Registrar's Signature

State Registrar 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ Joseph Benedict Long Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Hospice House Callaway **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Min. 1 🔀 M 2 🗆 F Hours 213-22-0231 87 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location Director ms 23a or 28a-f s must be notified Maryland St. Mary's Mechanicsville 10e. Street and Number 10f. Zip Code Funeral 41260 New Market Turner Road 20659 "natural", or items edical Examiner mu 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces? Completed by 1 🗷 Never Married 2 🗌 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 Divorced Year or Dates traumatic event, the Medical

December	23,	1922	Mar	yland					
				10d. Inside City Limits 1 ☐ Yes 2 🔀 No					
10g. Citizen of What Country?									

16b. Kind of Business Industry

USA

2010

4c. County of Death

St. Mary's

3. Time of Death

9:20 A

9. Birthplace (State or Foreign

Maryland

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Specify: White

2. Date of Death

8. Date of Birth (Month, Day, Year)

Month April

15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) 17. Father's Name (First, Middle, Last)

(Give kind of work done during most of working life. DO NOT use retired) Oil Distributor Office Manager 18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Russell

19a. Informant's Name/Relationship (Type, Print) Niece Harriet Elizabeth Johnson

Sylvester

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22796 Budd's Creek Rd. Leonardtown, MD

Marv

20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20c. Location - City or Town, State Charles Memorial Gardens May 4, 2010 Leonardtown, MD

proune 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

2. Name and Address of Facility
Mattingley-Gardiner Funeral Home
P.O. Box 270 Leonardtown, MD 20650

Immediate Cause (Final disease or condition resulting in death)

and Mental Hygiene. is marked other than

Department of Health Important: If item 27 any injury or other tr

Physician/

Medical

Examir

Physician/Medical

Completed by

Be

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Certificate:

Medical

Examiner

attending physician and for use as the burial-transit

Division of Vital Records, P.O. Box 68760

Page 1

Be

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last

	а	prostate Ca
-		D to (or as a consequence of):
	h	
	b. —	Dusits (or as a consequence on:
	٠. –	Due to (or as a consequence of):

Interval Between Onset and Death

Year

IF FEMALE 23b. Was decedent pregnant

in the past 12 months? 1 Yes 2 No

23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death Pregnant at time of death

9 Unknown

3 Ectopic pregnancy 5 Other (specify)

16a. Decedent's Usual Occupation

23d. Date of delivery Dav

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

3e. Did tobac	co use cont	ribute to the cau	se of death?
1 🗌 Yes	2 N o	3 🗌 Probably	4 🗌 Unkno

25. Was case referred to medical Hospital:

24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? 2 🗆 No 1 Yes

1 ☐ Yes 2 ☑ No 27. Manner of Death 1 Natural Accident Suicide

4 Homicide

only one)

5 Pending Investigation 6 Could not be

determined

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of injury

28c. Injury at work? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

4 Nursing Home 5 Residence 6 3 Other (Special Special 28d. Describe how injury occurred

29a. Certifier (Check

💇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D42597

29d. Date signed (Month, Day, Year) 4-30-10

28f. Location (Street and Number or Rural Route Number,

dress of person who completed cause of death (Item 23a) (Type, Print)

Jeffrey C. 26840 Pt. Lookout Rd. Leonardtown, MD Brown, M.D.

State Registrar

within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I

al or Attending P s after death. I Director: After

Hospital

31. Date filed (Month, Day, APR 3 0 2010

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AMonth 1 Evelyn Lipes Conova 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington . Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Hours 1 □ M 2 🗶 F Aug. 20, Year 923 West Virginia 230-20-4219 86 Director Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10West 10d. Inside City Limits Director Examiner must be notified Virginia 1 ☐ Yes 2XXNo Berkeley Martinsburg 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 542 Rockcliff Drive 25401 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 9 þ 1 Never Married 2 Married Yes 2 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural" 3 Widowed 4XXDivorced Completed White Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Day Care Provider Government other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Adam Guilliams Nora Maude Kelly permit, Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic o 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Connie M. Weaver-Granddaughter 1057 Beechwood Drive Hagerstown, Maryland 21740 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State April 27,2010 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 21. Signature of Funeral Service sborne Auneradity Home, P.A. 425 S. Conococheague St. Williamsport, MD 21795 Part. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ an way Chronic disease or condition 4-1000 Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine that y, leading to ministrate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of. or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the t IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? for Month Day Year Pregnant at time of death detached 9 Unknown g Unknow has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 X No this certificate 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 \(\text{Yes} 2 🗖 No မ 1 Inpatient 2 ER/Outpatient 3 DCA
28a. Date of injury
(Month, Day, Year) 28b. Time of injury
injury 28c. 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director; After 1 Natural 5 Pending work? 2 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 2 Di Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

30. Name and address of

31. Date filed (Month, Day, Year)

se of death (Item 23a) (Type, Print)

egistrar's Signat

2010

_ 26

\$26

Street

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Christina 3:53 PM 2010 Morgan 04 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Wicomica Hospice Dalisbur at th 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🕅 F Days Hours Min. 213-12-5315 93 Yrs **Director** /02/1917 be filed within reward and the series are shown arked other than "natural", or items 23a or 28a-f show arke other than "natural", or items 23a or 28a-f show artic event, the Medical Examiner must be notified at Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Maryland Somerset Princess Anne ۵ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21853 11974 Edgehill Terrace 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married \mathcal{M}_{org} $C \mathcal{L}_{c,i}$ $S \mathcal{H}_{org}$ Baltimore, Maryland 21215-0036If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify. Completed 3 ₩ Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) none Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o မ Frederick J. Flurer Della Sharrett injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If item 27 is any injury or Att. Roland Morgan, Jr. 11932 Jeffrey Lane, Princess Anne, MD 21853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ABurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Andrews Episcopal 4/22/2010 Princess Anne, Maryland signature of Funeral Service Licensee Hinand Fune farilithome 11673 Somerset Ave.. Princess Anne. M00295 Part 1. Enter the disease, or complications at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death mmediate Cause (Final Physician/ Thelmors disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or in that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 🛣 No Pregnant at time of death 9 Linknown 9 Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Tyes Other: 2 🔀 No Hospice ျာ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 🔀 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🔀 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🗖 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗍 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29505

Registrar

DHMH 17 Rev 7/2009

State

5302 CHINABERRY DR., SALISBURY, MD 21801

o. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREGORIO M. BELLOSO, M.D.;

31. Date filed (Month, Day, Year)

			For State Registrar	State of Maryla		artmen <i>tificate</i>			Mental Hy	giene Reg. No.)	010	11.273
			Decedent's Name (First, Middle, Last)						2. Date of De	ath	UIL	3. Time of Death
	Physicia Medio		Robert	Mann					Month 0 4	Day	ZO10	3.45 PM
	Examin		4a. Facility Name (if not institution, give st. University of Maylan		nter			ocation of Death)	4c. C	ounty of Deat	h
	Funeral Director		5. Social Security Number 6. Sex		last birthday) Yrs.	If Under Months		If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Aug • 5	th ay, 1 ^{Year)} 7	9. Birl	thplace (State or Foreign untry) Lrginia
			Usual Residence of Decedent	12					Hug. J	<u>, 1737</u>		riginia
	land f sho	tor	10a. State 10b. County	10c. C	ity, Town or Lo	cation						10d. Inside City Limits
	Man 28a- notifie	irec	Maryland Washing	ton Hag	erstown	_						1 Yes 2X No
	the the	rai	10e. Street and Number			10f. Zip		7.4.0			n of What Co	
	ath w	Funeral Director	226 South Fork Dri	V E 2. Was Decedent Ever in U	I.S. 13. V	Vas Decede		.740 panic Origin? (Sp	ecify Yes or No		Lted St	
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give		f Yes, speci		panic Origin? (Sp , Mexican, Puerto Spec <i>ify:</i>	Rican, etc.)		Black, White	e, etc.
9500-61212	nours latura ical E	Completed	15. Decedent's Edu		16a. Deced	lent's Usual	Occupat	ion		16b Kind	Whi	
212	n 72 t e. ian "n Medi	mp	(Specify only highest grade Elementary/Seconday (0-12)	completed) College (1-4 or 5+)	(Give I	kind of work O NOT use	done du	ring most of work	ing	1		County
7.	withi giene Jer th t, the		8	comege (i i ci ci)		Super	vișc	r		Dept.	of Ti	ansportatio
	e filed	To Be	17. Father's Name (First, Middle, Last)					18. Mother's Nan	e (First, Middle	Maiden Su	rname)	
Maryland	uld be d Men narke natic	_	Garland R. Mann		-			Hilda Fa				
Za	2 sho th and 27 is r traun	3	19a. Informant's Name/Relationship (Type	, Print)		Ü		nd Number or Rur				
<u>o</u>	and Heal Item 2		June A. Mann/ Wife 20a. Method of Disposition	20b.	Place of Dispo	sition (Nam	e of		<u>Hagers</u> Date		<u>lary⊥ar</u> ation - City or	nd 21740 Town, State
ē	age 1 ent of nt: If i		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		cemetery, cren ne Grov			:	/2010		-	aryland
Baltimore,	mit. F partm porta y inju	12	21. Signature Funeral Service Drensee	16								
<u>מ</u>	8 2 E 8	1	Spall & C	wow.	16	21 0 _F	ossu	mtown P	ke, Fr	ederic	k,Mary	land 21702
	Physician/	0.8	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	eations that caused the dea cause on each line.	ath. Do not ente	er the mode	of dying,	such as cardiac	or respiratory a	rest,		Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (r as a conse		Failu	re					Iweek
	ted I Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Pro Underly (Disease or injury)									11 days
_	cate be executed physician and the burial-transit	al Ex	that initiated events c. resulting in death) Last	Due to (or as a conse	quence of):			ic ane	insom			11 days
9	cate by phys	ledical	d		0(2007)							-3
DOX DO	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c. If yes, outcome of pregr 1 Live Birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic p Other (spe	regnancy ec <i>ify)</i>			23	d. Date of del Month	livery Day Year
л Э	at the		Part II. Other significant conditions cont	ributing to death but not re	esulting in the u	nderlying c	ause give	n in Part I.	23e. Did 1	obacco use	contribute to	the cause of death?
'n.	uires t n sign ald be	Completed by	hypertension, di	abetes, a	ronany	cirt	eng	disease	1 🗆	Yes 2	No 3 \square P	robably 4 🗆 Unknown
or vital Records,	w requ	plet			,		,		24a. Was		24b. Were au	topsy findings available completion of cause of
ě	The la	Com								ormed?	death?	2 No
<u>.</u>	sian: Pertifica	Be	25. Was case referred to medical examiner?					ce of Death (Chec				
>	Physic this c al dire	<u>و</u>	1 ☐ Yes 2 No Ho 27. Manner of Death	spital: 1 Inpatient 2				4 ☐ Nursing H				ify)
0	ding F h. After funer	ate	1- Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	M 28	lc. Injury a work?	es 2 🗆 No	28d. Describe	how injury o	ccurred	
DIVISION	Atten r deat ctor:	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h				es 2 INO	28f. Location (Street and N	lumber or Rui	ral Route Number,
5	al or s afte		4 - Homicide determined	building, etc. (Speci	fy)				City or To	vn, State)		
	e Hospit 124 hour e Funera leted fille	Medical	(Check 2 Medical Examine	ian: To the best of my known: On the basis of examination Practioner: To the best of r	on and/or invest	igation, in m	ny opinion	, death occurred a	t the time, date	and place, ar	nd due to the	cause(s) and manner state
	To the within To the comp	2	29b. Signature and the of certifier	7/	ny knomougo, c	29c.	License r	number			signed (Month	
)		17/1/	7 MD		1	659	53053	3	4/1	9/10	
	i		30. Name and address of person who core	npleted cause of death (Ite 22 S. 32. Registrar's Sign	m 23a) (Type, P	rint) 2 St	B	a Himore	, MD	212	.01	
	Stat	е	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature 🥻	har	1.1					
	Registra		APR 2.1	DE ABLANCE	W B.	THE WALK						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Joan Teresa McInerney 3:48 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death the icomic If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** England 1 □ M 2 🔀 F 72 Months Days Hours 10/77/1937 225-66-0281 Director Usual Residence of Decedent shov 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland injury or other traumatic event, the Medical Examiner must be notified at Director 28a-f 1 Yes 2 No Worcester Berlin 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral items 23a 65 Mistic Harbor Blvd. 21811 Great Britain ld be filed within 72 hours after death wental Hygiene. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ò þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: "natural" 3 🛚 Widowed 4 🗆 Divorced Completed white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Bartender Restaurant 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ Edward McDonald Blanche Rogers Page 1 and 2 should I ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Donna Blanton /daughter 1601 Neil Armstrong #216. Montebella. CA 90640 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State Cape Henlopen Crem. 4/14/2010 Frankford, UE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MPETASTATIC CANCRIL disease or condition Medical resulting in death) Examiner MRTASTASI Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 1 Yes 27 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence nours after death. neral Director: After this co d filled in by the funeral dire 1 🗌 Yes 2 🗷 No Certificate: To 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Sertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 0005840 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DN 12

Gffuum

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 25, Day 2010 Year Ruth 11:10 Pm The1ma Morris 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death

Herne
1/1

	Examin	er			e street and number)			or Location of Dea	4c. County of Death				
				-	sing Cente			nardtown			Mary's		
	Funeral Director		5. Social Security No. 219–16–1	050	Sex 1 □ M 2 🖾 F	(In yrs. last birt	hday) If Under 1 Year Months Days		8. Date of Birth (Month, Day, August 3	9. Bi Year) Co 1917 Mar	rthplace (State or Foreign ountry) yland		
	mo d	_	Usual Residence of 10a. State	Decedent 10b, County		10c. City, Towr	or Location				404 1-11-07-11-7		
	Marylan 28a-f sh otified a	Director	Maryland		. Mary's	Toc. City, Town		e11			10d. Inside City Limits 1 ☐ Yes 2 ☑ No		
	a or		10e. Street and Nun	nber			10f. Zip Code			10g. Citizen of What C	ountry?		
	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. At the fleath and Mental Hygiene. Or other traumatic event, the Medical Examiner must be notified at or other traumatic event, the Medical Examiner must be notified at	Funeral	20604 G	olden The	ompson Road			20606		USA			
		Fu	11. Marital Status		12. Was Decedent E	ver in U.S.	 Was Decedent of If Yes, specify Cub 	Hispanic Origin? (S oan, Mexican, Puer	Specify Yes or No- to Rican, etc.)		14. Race - American Indian, Black, White, etc.		
9000	urs after ural", or Il Exami	ted by	1 ☐ Never Marri 3 🕱 Widowed	ied 2 Married 4 Divorced	1 ☐ Yes 2 🐼 I If Yes, Give Year or Dates.	No	1 ☐ Yes 2 🛣 N			Specify: Wh			
5-	"nat	ble	(Spe	 Decedent's Intercept only highest gas 		16a.	Decedent's Usual Occu (Give kind of work done	during most of wo	orking	16b. Kind of Business	Industry		
2121	within 7 giene. her than t, the Ma	e Completed	Elementary/Second 12	onday (0-12)	College (1-4 or 5-	+)	life. DO NOT use retired Homema	1)		Own Home			
pu	filed tal Hy d oth	To Be	17. Father's Name (f	-				18. Mother's Na	ame (First, Middle, N	Maiden Surname)			
yla	ild be Ment narke natic	۲	James Go	olden The	ompson Sr.			Rut	th Margar	et Woodall			
, Mar	id 2 should be file salth and Mental n 27 is marked of er traumatic eve		19a. Informant's Na Mary O.		Type, Print) Daughter		. Mailing Address (Stree 3200 Kays Wa			-	ip Code)		
Baltimore, Maryland 21215-0036	Page 1 an ment of He ant: If iten ury or oth				☐ Removal from State	cemeter	f Disposition (Name of ry, crematory or other pla Heart Catholic Cemetery	Apri	Date 1 29,2010	20c. Location - City of Bushwood, Mar	r Town, State yland		
Balt	permit. Page 1 Department of Important: If i any injury or once.		21. Signature of Fun	aeral Service Sicen	Jardesie)			ess of Facility ey-Gardi 270 Le	ner Funer onardtown	al Home, I , MD 20650	P.A.		
			23a. Part 1. Enter the	he disease, or con	nplications that caused one cause on each line.	the death. Do n	ot enter the mode of dy				Approximate Interval Between		
	Priysician/		Immediate Cause (I	Final	0	eumer	111				Onset and Dea		
	Medical		resulting in death)	•	a. Due to (or as a	consequence of	of):						
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0	be ey sician buria				. 4								
376	icate g phy is the	ledi			- u								
89	certif anding use a	M/N	IF FEMALE; 23b. Was decedent		23c. If yes, outcome o		2			23d. Date of de	elivery		
. Box 68760	that the death certificate be executed red by the attending physician and detached for use as the burial-transit	Physician/Medical	in the past 12 r 1 ☐ Yes 2 9 ☐ Unknown	nonths? I No	4 ☐ Pregnant at 9 ☐ Unknown		n 3			Month			
P.O.	that the poly deta	>	Part II. Other signifi	icant conditions	contributing to death bu	t not resulting i	n the underlying cause g	iven in Part I.	23e. Did tob	pacco use contribute to	o the cause of death?		
JS,	uires in sign	ed b	_ COP	D	Lements	a , 1	Apperten	non	1 □ Y	es 2 No 3□F	Probably 4 🗆 Unknown		
Ö	w required to see	Completed	His	Lac	ture	6			24a. Was a		topsy findings available completion of cause of		
Bec	The la ate ha	Som	7						autops perfori 1 Yes				
_ _	ian: ertifica ctor, p		25. Was case referre	d to medical			26. F	Place of Death (Che		7			
5	hysic his ce Il dire	욘	1 🗆 Yes 2 🕽	No	The State of the S		tpatient 3 L DOA	ner: 4 Nursing	Home 5 ☐ Reside	ence 6 🗆 Other (Spec	cify)		
on of	ending P sath. rr: After t ne funera	Certificate:	27. Manner of Death 1 Natural 2 Accident	5 Pending Investigatio			ime of 28c. Injury wor M 1		28d. Describe ho	w injury occurred			
Division of Vital Records,	ial or Attors after de al Directo		3 ∐ Suicide 4 ☐ Homicide	6 Could not be determined			rm, street, factory, office		28f. Location (St. City or Town	reet and Number or Ru , State)	ıral Route Number,		
	To the Hospital or Attending Physician: The law requires the within 24 hours after death. To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be	Medical	(Check 2	Medical Exam	niner: On the basis of ex	amination and/o	death occured at the tim r investigation, in my opin edge, death occurred at t	ion, death occurred	at the time, date an	d place, and due to the	cause(s) and manner stated.		
	70 th with To th		29b. Signature and t	itle of certifier	7/		29c. Licens	se number	2	9d. Date signed (Mont	V, Day, Year)		
Ne				ess of person who Boyd, M.D.	completed cause of de				dtown, MD 2	///			
	Stat Registra	e	31. Date filed (Month			s Signature	back						
			***		1	- 4							

1 - For State Registrar

Physician/

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 19/2010 Charlotte Patricia Murphy 4:53P М Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Carriage Hill-Bethesda Bethesda Montgomery Social Security Number If Under 1 Year . Age (In yrs. last birthday) If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 X Days 0371071925 Director Missouri 579 24 1435 85 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel West River 1 ¥ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4994 Sudley Road 20778 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Department of Justice Lawyer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be filed f Health and Mental H item 27 is marked ot ည Maurice P. Murphy Cecile Hoehn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Katherine K. Cawood/Personal</u> 4994 Sudley Road West River, MD _20778 item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 and Department of H Date Important: If it any injury or o 1 XBurial 2 Cremation 3 Removal from State Gate of Heaven 4 ☐ Donation 5 ☐ Other (Specify) 04/24/2010 Silver Spring, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave., NW Washington, DC 20016 23a. Part 1. Enter the Isea (L., or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure / ist only one cause in each line. nterval Between Immediate Cause (Final Onset and Death Physician/ Atrial Fibrillation disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjuy that initiated events resulting in death) Last Examine Little to (or as a consequence of) Dissection of Aorta and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Cerebrovascular Accident IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Seizures 1 Yes 2 No 3 Probably 4 L Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has certificate 1 ☐ Yes 2 ☐ No Yes 21 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital မ 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 X Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred iniury 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined

r.C. **BOX b8/60**that the death certificate be executed Box 68760 P.0. Records, To the Hospital or Attending Physician: Division of Vital thin 24 hours after death.

the Funeral Director: After mpleted filled in by the fun

DHMH 17 Rev 7/2009

State

Registrar

Medical

29a. Certifier

Dr.

(Check

29b. Signature and title of certifier

nomus V.

Thomas V. Joseph Month, Day, Year) APR 22

22

JOSUNH

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

50 W. Edmonston Dr. Suite 207 Rockville, MD 20852

29d. Date signed (Month, Day, Year)

04/20/2010

29c. License numbe

D0047330

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Horil Francina Mumford Year **20/0** 1412 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death RHIKULA REGIOVAL 5048541 NICARCO **Funeral** Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 SC 1 □ M 2 😾 Days Months Hours 249-52-5229 Director 76 Usual Residence of Decedent show 10a. State 10c. City, Town or Location be filed within 72 hours after death with the Maryland 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits Worcester MD Berlin 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 207 Branch Street 21811 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Completed by Black, White_et 1 Never Married 2 Married Yes 2X No Baltimore, Maryland 21215-0036 African-If Yes, Give 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Specify Year or Dates American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 8th Domestic Various Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James McCants permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Georgia Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vanessa Dennis/daughter 207 Branch Street, Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) New Bethel UMC Cem 4/23/2010 Berlin, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lewis N. Watson Funeral Home, PA 1618 West Road, Salisbury, MD 21 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Envertion/ Onset and Death ASCUD disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Day Year signed by the a d be detached f 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by cate has been sig page 2 should b Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? Yes No the funeral director Be 25. Was case referred to medical 26. Place of Death (Check only one) No Hospital ျှ 1 🗌 Yes Other: Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work? Accident Investigation 1 🗌 Yes 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by ☐ Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 29d. Date signed (Month, Day, Year) D63199

Registrar

30. Name and

CARROLL

ress of person who completed cause of death (Item 23a) (Type, Print)

MD

St. SALIS bury ma 21801

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 04 Year SR. ton 2240 M 2010 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner W. Comico Salisbur DEER Hospital Center Head If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6 Sax 7. Age (In yrs. iast birthday) **Funeral** Months 1 ☑ M 2 ☐ F 90 061-12-0117 Director Feb. 6, 1920 maryland Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23s or 28s-f show traumatic event, the Medical Examinar must be natified at 1 ☐ Yes ₽ No Director Somerset Marion Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with Hwy. 21838 Crisfield 6626 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Myes 2 No If Yes, Give Year or Dates: 1943-46 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specity Specify: BIACK þ 3 Midowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any njury or other traumatic event, Ita Madic 2003. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 7th grade

17. Father's Name (First, Middle, Last) School Bus Contractor Bus Delver 18. Mother's Name (First, Middle, Maiden Sumame) Maddor Orlando Lovie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EHon P. 8391 Salisbury Md. 21804 Maddex Jaz. - Son Hilda DR: ye 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. L. cation - City or Town, State 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 4-24-10 madder family cemotery Kingston, Md Anthony E. Warri 21. Signature of Inneral Service Licenses 22. Name and Address of Facility FiH. 30639 Hampdon Ave Princess Anno, ml, 21853 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner 2 mo Metastatic Adeno carcinoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Gastric Cancel Due to (or as a consequence of): Completed by Physician/Medical as signed by the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 1 Yes 2 No 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? this certificate 1 ☐ Yes 2 ☐ No Division of Vital 1 🗌 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 4 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 HO 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ANatural 5 Pending Injury death. 1 Yes 2 No М 4 hours after death. 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, faclory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours at To the Funerel D completely filled in 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) michael 1. 04/19/2010 1000 2038 P. OBOX 4+ 2018 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

Deera

351

32. Rigistrar's Signature

Buchness

Michael P.

Head Hospital Rd.

ry MD. 21802

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 222 3 LINNIE REBECCA MACE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ALLEGANY WESTERN MD REGIONAL MEDICAL CENTER CUMBERLAND 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. last birthday) **Funeral** 1 🗆 M 2 🗶 F Months Hours Min (Month, Day, Year) 06-08-1940 69 215-40-3570 Director MARYLAND Usual Residence of Decedent r 28a-f shov notified at shov 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 XNo ALLEGANY LAVALE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a o Funeral 21502 504 FAYETTE STREET U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🛣 No Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates WHITE Specify Completed 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) **GROCERY** SALESMAN permit. Page 1 and 2 should be filed wit.
Department of Health and Mental Hygier important: If item 27 is marked other than injury or other than 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
ANNA MARY MCKENZIE BLANK ೭ CARL BLANK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 504 FAYETTE STREET LAVALE, MD 21502 RICHARD MACE SON Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ■ Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place, PATRICK'S CEM MT. 05-06-2010 SAVAGE, MD ST. Donation 5 Other (Specify) of Funeral Service Licensee

M. Sower 21. Signature 22. Name and Address of Facility m0054 60 W MATN 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between et and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence oi): Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death Unknown Day 2 No 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed' death? 2 No 1 🗌 Yes Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 25 Other: မ s after death.

I Director: After this conditions of the funeral directors and in by the funeral directors. 1 Inpatient 2 Fr/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work 5 Pending Yes 2 No Accident Investigation 6 Could not be Suicide 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral I Medical 29a. Certifier 1- Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сотріете Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: Jo He best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) and address of person who completed f death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

3 DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year Lorraine Hope Neil 04 20 2130 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Coastal Hospice at the Lake Salis bur Wicomico 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MD 8. Date of Birth Funeral 1 M 2 🔼 F Hours Min. 12/16/1931 78 Director 222-18-2843 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Berlin 1 Yes X No Worcester 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 42 Teal Circle 21811 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 $_{\text{Specify}}$ white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Elementary/Seconday (0-12) life. DO NOT use retired) College (1-4 or 5+) ICI of America telephone operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Flora Thacker Charles Meeds OYraine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 42 Teal Circle Berlin, MD 21811 Melanie Neil (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/24/2010 New Castle DE 4 ☐ Donation 5 ☐ Other (Specify) Gracelawn Mem. Park ral Service Licen 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin, MD 21811 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final √Physician/ END TALLEZ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence or) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital Other: ပ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural Natural injury 5 Pending Accident Investigation M Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

DN5

State Registrar

29b. Signature and title of certifier

Huram

31. Date filed (Month, Day, Year)

32. Redistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c, License number

733

D0058410

SKIBURES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 20 Day 2010 Year Owens Parker 1:05 p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 906 Heron Drive Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country D. C. 1 □ M 2***** F Sept. 28 (Month, Days Year) 1923 578-20-6751 Months Days Hours Min. 86 Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County with the Maryland 10a. State 10c, City, Town or Location 10d. Inside City Limits Director Maryland 1 🗆 Yes 2 🎦 No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 906 Heron Drive 20901 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 🛣 No Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify Specify: White 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. US Department of Elementary/Seconday (0-12) College (1-4 or 5+) 12 Administrative Assistant Agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked ot r other traumatic ever permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve Joseph M. Owens Belinda Feeney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael P. Parker/Son 28 Madison Place, Annapolis, MD 21401 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State April 2010 Gate of Heaven Cemetery 1 🖺 Burial 2 🗌 Cremation 3 🗌 Removal from State Silver Spring, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Francis Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Ph sician/ Uremia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner End-Stage Renal Disease 3 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (of as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burnal-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension, Anemia 1 ☐ Yes 2 HNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 XNo 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Tes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5X Residence 6 Other (Specify, Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 XNatural iniury 5 Pending 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) artifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D41662 April 21, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Saeed

Æronfli, MD

arke

32. Registrar's Signature

7610 Carroll Avenue, #480, Takoma Park, MD 20912

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Merrill Rudolph PERESCHUK Month Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Washington Hagerstown 5. Social Security Number 219–36–3275 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. July 12, Hours Year 1940 1 X M 2 □ F 69 Mary Land Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland 10d, Inside City Limits Director iral", or items 23a or 28a-f s Examiner must be notified Maryland Washington Hagerstown 1 Yes 2X No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 12204 Bucky Avenue 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No 1960- Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: "natural", Specify. Completed 3 Divorced 1965 permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other tranmatic event, the Medical any injury or other tranmatic 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) clerk city government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pauline F. Dutrow John Marsh Pereschuk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21740 12204 Bucky Avenue, Hagerstown, Maryland Shirley A. Pereschuk - wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place).
Cedar Lawn Memorial 20a. Method of Disposition 20c. Location - City or Town, State Date 28 2010 1 🖾 Burial 2 🗌 Cremation 3 🗌 Removal from State Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine rany, Isaaing to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to for as a consequence of sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? à 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 🛮 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A: completed filled in by the ft Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 25 4166 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JH-34

State Registrar onth, Day, Year)

2010

31. Date filed (Month,

(impv)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Linda Peluso Ann May 2 2:41 P . Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hagerstown Washington 138 S. Prospect St. Apt. 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 ⋤ F Months Days Hours Min. Sept.13,1956 217-70-4759 53 Maryland Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Md. Washington Hagerstown 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 138 S. Prospect St. Apt. #5 Funeral 23a 21740 U.S.A items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. ō þ 1 Never Married 2 Married 2X No 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2x ☐ No Specify: White should be filed within 72 hours aft and Mental Hygiene. 'is marked other than "natural", Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Hiring Agency Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John H. Leonard Jean D. O'Connell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl ment of Health a 28 Mt. View Dr. Boonsboro, Md. 21713 Jean D. Leonard (Mother) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Smithsburg Crematory 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Important: If ii any injury or o May 2016 1 ☐ Burial 2x Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, Md. Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. MO1414 J.L. Davis Funeral Home Smithsburg, Md. 21783 rt T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate terval Between ny t and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 2 No ed by the a detached t 9 Unknown 9 Unknown P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ SINUSHY Division of Vital Records, cate has been sig page 2 should b Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 XNo Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Matural Natural 5 Pending work? 1 🗌 Yes 2 🗌 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) Name and Address of person am

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

DI IIVII 17 110V 77200

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ 18 11:55 AM April Betty Μ. Roos Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F Months Days Hours Min. (Month Day, Year) ec 13, 1924 Nebraska **Director** 85 352-18-9988 Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 ¥ Yes 2 ☐ No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö ral", or items 23a or Examiner must be Funeral 212 Bookham Lane 20877 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2**½** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify. 3 ₩ Widowed 4 □ Divorced White Year or Dates 27 is marked other than "natural traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Office Manager Law Firm Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Clifford Mahannah Frieda Griess permit. Page 1 and 2 should Department of Health and M Important: If item 27 is mal any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul F. Roos/son 212 Bookham Lane Gaithersburg, Maryland 20877 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 4/21/2010 Woodbine, Maryland 21. Sign of re of Funeral Service Lic Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD M00957 atinal Momas Approximate Interval Between Onset and Death 2 hours 23a. Part the Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Acute Myocardial Infarction hours Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Liner Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Day Pregnant at time of death Yes 2 □**X**No 9 Unknown detached g 🗌 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dementia 1 Yes 2 MNo 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No. မ 1 Inpatient 2 X ER/Outpatient 3 IDOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 1 XNatural Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

within 24 hours after death To the Funeral Director: A

State Registrar 29b. Signature and title of certifier

Joel E. Buzy,

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

9901 Medical Center Drive Rockville, Maryland 20850

C

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 14285 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Daniel Alfonso Rocha 2010 April P M 8:25 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Suburban Hospital Bethesda . Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, April 19 **Funeral** 9. Birthplace (State or Foreign 1 **X** M 2 □ F Months Days Hours Min. 214-08-0534 Columbia Director 50 Vrs 1959 Usual Residence of Decedent 10a. State 10b. County the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Maryland Montgomery North Bethesda 1 Yes 2 No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral permit. Page 1 and 2 should be filed within 72 hours after death with 5702 Luxemburg Street #100 20852 United States items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. ō Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes. Give 1 X Yes 2 □ No Specify: Columbian "natural", Specify: White 3 Divorced 4 Divorced Year or Dates item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) d Mental Hygiene. marked other tha Producer/Journalist Newsmedia Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Juan C, Rocha Esther Garzon and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Health tem 27 Elizabeth Rocha / Wife 5702 Luxemburg St. #100, N. Bethesda, MD 20852 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot 20c. Location - City or Town, State Aprilatel9. cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State 4 Donation 5 Other (Specify) Resthaven Crematory 2010 Frederick, Maryland 21. Signature of Furieral Service U ensee Restnaven Funeral Services, Skkot Cody P.A. Catoctin Mountain Hwy. Frederick, MD 21701 23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Hepatic Failure Medical Due to (or as a consequence of) Examiner Pancreatic Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that is itsed as or iinjury Due to (or as a consequence of) use as the burial-transi that initiated events resulting in death) Last physician and Due to (or as a consequence of): Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month signed by the a g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? cate has by page 2 sl 24a, Was an autopsy certificate performed? 1 Yes 2 No ☐ Yes 2 😿 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 To No ဂ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 X Natural wor

OCHA 4/15 Hospital or Attending Physician: Vital of Division ANIEL 0

Registrar

State

Accident

Suicide

4 Homicide

29a. Certifier

(Check

only one)

29b. Signature and title of

31. Date filed (Month, Day, Year)

3 🗆

Vinni Juneja, M.D.

APR

Investigation

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

6 Could not be

within 24 hours after death

To the Funeral Director:

completed filled in by the

Medical

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated,

0066990

1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

6420 Rockledge Dr. Bethesda, MD 20817

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year)

City or Town, State

State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 04/16/2010 Physician/ THOMAS DEWITT REYNOLDS 1311 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery 6. Sex 1X M 2 D F If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Days Hours 07/25/1929 **Director** 343-26-3912 80 Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 X Yes 2 No MD Montgomery Gaithersburg 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ms 23a or must be r Funeral 8620 Oakmont Street 20877 USA "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc þ 1 Never Married 2 XMarried XYes 2 No 1957-Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. White Specify: 3 Widowed 4 Divorced Completed 1959 and Mental Hygiene.
s marked other than "natura umatic event, the Medical E Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Medical Doctor Private Practice Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Ralph C. Reynolds Irene DeWitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann M. Reynolds - wife 8620 Oakmont Street, Gaithersburg, MD 20877 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State Ardent Cremation Svc 4/19/10 4 Donation 5 Other (Specify) Hanover, MD Snowden Funeral Home 21. Signatu 201 uneral Service Licenses 2. Name and Address of Facility 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, of complications that caused the death. Do shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Weeks Immediate Cause (Final Physician/ Pneumonia Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of): sician and burial-transit certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician the dor use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year ☐ Yes 2 ☐ No 9 Unknown detached 9 Unknown nis certificate has been signed by director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Aortic stenosis, Atrial fibrillation, CVA Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of RESHOLDS this certificate has autopsy performed?
Yes 2 XNo death? 1 ☐ Yes 2 ☐ No Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2X No ပု 1 X Inpatient 2 -ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Jo completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After t To the Hospital or Attending within 24 hours after death. To the Funeral Director: After XNatural 5 Pending work' 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined THOMAS Medical 29a Certifier 1 🎇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4/16/10 D0060117 MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 7/2009

State

Registrar

Eric J. Park

31. Date filed (Month, Day, Year)

PR

22

Georgetown Road, Bethesda, MD 20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8600 Old

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Raymond Dale Riley 19, 2010 6:00 a M April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1759 Baltimore Annapolis Blvd. Annapolis Anne Arundel 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year, **Funeral** Months Days Hours Min. 1**X** M 2 □ F 215-20-0539 81 Director 11/03/1928 Maryland Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it. In Medical Examinations is provided as Director 1X Yes 2 □ No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1759 Baltimore Annapolis Blvd. 21401 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married XYes 2 🗆 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give AirForce 2 Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) National Security Elementary/Secondary (0-12) College (1-4or 5+) Agency secret service agent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Disharoon Riley Sr. May Jackson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hwa Riley/spouse 1759 Baltimore Annapolis Blvd, Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 22 2010 4 Donation 5 ☐ Other (Specify) Jerusalem Cemetery Parsonsburg, MD Signalure of Funeral Service Licens 2HOTTOWAY TUNETAL Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 (Dongrow) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** nela disease or condition resulting in death) /Medical as a consequence of Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □ No Month Day Pregnant at time of death 5 Other (specify) the 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed .24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2 🗆 No 1 □ Yes 🔑 🗖 No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner eath 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Box 68760, P.O. Division of Vital Records,

29a, Certifier 1 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ste 300 Amapoles MD 214 U/ Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Medical

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 1, 2010 12:32 AM Robert Lee Ray Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick 8110 Rocky Springs Road 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 D F Days Hours Min Feb. 13 Year 1942 218-38-1809 68 Marviand Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Frederick Frederick Maryland 1 Tyes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 21702 8110 Rocky Springs Road U.S.A. death v 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes XX No Black, White, etc. à 1 Never Married XX Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes XX No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If Item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Government Firefighter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna Louise Derry Norman Elwood Ray b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code). 8110 Rocky Springs Road, Frederick, MD 21702 19a. Informant's Name/Relationship (Type, Print) Mrs. Rose M. Ray, wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If Ite
any injury or ot Mount Olivet Cemetery May 5m 2010 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Frederick, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee ²² Name and Address of Facility ford PA Funeral Home 106 East Church St., Frederick, MD M00255 21701 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) us ce of): Medical Due to (or as a cons Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ signed by the atter in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown Completed page 2 should . Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 1 Yes Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s)
Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. D5164 Sheh 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jhon son 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 04:40 PM April Frank Pierce Savage Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1433 West Old Philadelphia Road North East Cecil Social Security Number Sex 1X M 2 □ F If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov 12, 9. Birthplace State or Foreign Pocomoke City Maryland **Funeral** Days Hours Min. **Director** 213-22-6521 1928 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Examiner must be notified at Director 1 ☐ Yes 2 X No Maryland Cecil North East 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? 23a Funeral 1433 West Old Philadelphia Road 21901 United States items 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ō þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: White Specify: "natural" 3 👿 Widowed 4 ☐ Divorced Completed Year or Dates. 1946-194 other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event the Max Veterans Elementary/Seconday (0-12) College (1-4 or 5+) 12 Firefighter <u>Administration</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ္ပ Walter T. Savage Hattie J. Henderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 264 Harrisville Road, Colora, Maryland Valerie McMullen / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Aprifite 24, North East United Methodist Cemetery 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 North East, Maryland 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Prostate Ph sician/ lnknown Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) sician and burial-transit Exami that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Yes 2 No signed by the a g Unknown 9 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Congestive Heart Failure, Hypertension, Coronery cate has been sig page 2 should b Completed 1 Yes 2 No 3 Probably 4 M Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an arkry disease autopsy performed? death? certificate 1 ☐ Yes 2 🛣 No Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 💢 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Sulcide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Division of Vital Records, Hospital or Attending Physician: The law requires within 24 hours after death

To the Funeral Director; A

completed filled in by the f

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) D0059903

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Pamela LeClaire, 102 East Cecil Avenue, North East, Maryland

21

2010

State Registrar

Medical

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3, Time of Death 21^{Day} Month 4 Physician/ 2010 7:45 P M Jessie Lee Sturgis Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 5811 Taylor Landing Rd. Worcester Girdletree 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min 1 🛛 M 2 🗆 F Days Hours 58 3/297 1952 Director 219-56-9198 MD Usual Residence of Decedent or 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-1 show and Mental Hygiene. 'is marked other than "natural", or items 23a or 28a-f shor raumatic event, the Medical Examiner must be notified at Director 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 XNo MD Worcester Girdletree 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? Funeral 5811 Taylor Landing Rd. 21829 USA 12. Was Decedent Ever in U.S 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces?
1 X Yes 2 □ No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛚 No Specify: If Yes. Give **Black** 3 🗌 Widowed 4 🗆 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Kelly Foods Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Reese Sturgis Maisie Taylor other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Sturgis / wife 5811 Taylor Landing Rd., Girdletree, MD 21829 permit. Page 1 and 2
Department of Healt
Important: If item 2
any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State St. Pauls Cemetery 4/24/2010 4 Donation 5 Other (Specify) Berlin, MD Signature of Fundal Service Licens 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 ulo Approximate Interval Between 23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause on caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, val Betw Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially flat conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 1 No 23d. Date of delivery Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) 1 ∐ Yes ∠ ¶ g ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an after death.

Director: After this certificate has prior to completion of cause of death?

1 Yes 2 No autopsy perform Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital Other: ပ ER/Outpatient 3 DOA 1 Inpatient 2 I 5 Residence 6 Other (Specify) 27. Manna of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred **V** Natural injury work? 5 Pending 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one 29b. Signaty 29c, License number 30. Name and ed cause of death (Item 23a) (Type, Print) DN 5+1 egistrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Vear Month **Physician** 2010 Sware lancy Apri /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's 5. Social Security Number Leonardtown,
If Under 1 Year | If Under 24 Hrs. MD Mary's HOSpita Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** Hours Year) Min. TINK 1 □ M 2 🔀 F Months Davs Director April 27,2010 20 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f shov the Modical Expedient must be retified at 1 ☐ Yes 2 ☑ No Director Maryland St. Mary's Charlotte Hall 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8990 Denton Run Pl. 20622 IISA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ∐Yes 2★ No If Yes, Give Year or Dates: 1★ Never Married 2 Married 1 □Yes 🏖 No Specify ş Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Unkown Unkown is marked other 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) 1 and 2 should be Health and Mental Savilla H. Fisher Daniel M. Swarey 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai once. 8990 Denton Run Pl. Charlotte Hall, MD 20622 Father 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) April 28, 2010 Mechanicsville, Maryland Hertzlers Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Lity Mattingley-Gardiner Funeral Home, P.A. Mattingley-Gardiner Funeral Home P.O. Box 270 Leonardtown, MD 2062

23a. Part 1. Inter the disease, or constitutions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. P.O. Box 270 Leonardtown, MD 20650 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician prematurity /Medical Due to (or as a consequence of): Examiner hydrops fetalis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) physician Physician/Medical as attending 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 D Ectopic pregnancy for L in the past 12 months? 1 ☐ Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s has autopsy performed Yes 2 certificate 1 □Yes filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier completely and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific

O Rime

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar 30. Name and address of person who completed ca

APR 30

Erin L. His
31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

sse of death (Item 23a) (Type, Print)

51. Mary 's Hospital

D00623

25500 Point

Leonard town.

Lookout

MD 20650

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 123 William Theodore Shaw, Sr. 25 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Washington County Hospital Hagerstown 7. Age (*In yrs. last birthday*) 65 Yrs. If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Numbe **Funeral** (Month, Day, 1 🏹 M 2 □ F Days Hours Min. 214-42-0813 T944 Illimois Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington County 1 ☐ Yes 2X No Hagerstown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1401 Haven Rd. 21742 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. "natural", Specify: Completed 3 Widowed 4 Divorced White item 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Serviceman U.S. Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F Elizabeth Keesecker Theodore Keesecker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 1401 Haven Rd. Hagerstown, MD 21742 Juanita M. Shaw-wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State Smithsburg Crematory 4-27-2010 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home Eastern Blvd. North Hagerstown. 23a. Part 1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician Pseudomones Preumonia disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exam The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Day Pregnant at time of death the 2 hed fo 9 Unknown Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Tracheal-Bronchial Sterosi's Division of Vital Records, Diabetes. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed? this certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 🗌 Yes 2 1 Hipatient ျ 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Deat 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Ecrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D62588 me and address of person who completed cause of death (Item 23a) (Type, Print)
NITH MADUA. TD. 251 E. Antietan St. Hagerstown, TW

State Registrar MBAOUA

JUDITH 31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2010 Burton Edward Schlosburg 7:50 am 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomery Holy Cross Hospital Social Security Number 6. Sex 1 🖾 M 2 🗆 F Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Months (Month, Day, Year) 12/28/1933 Washington. 579-48-0010 76 Usual Residence of Deceden 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tes 2 X No Silver Spring Montgomery Maryland 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? U.S.A. 10711 Tenbrook Drive 20901 12. Was Decedent Ever in U.S. Armed Forces?

1 12 Yes 2 No 1953If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 X Married 1 ☐ Yes 2 🗓 No Specify. White 3 Widowed 4 Divorced 1994 Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **5**+ Electrical Engineer IBM17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ida Elizabeth Wolowitz Daniel Schlosburg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10711 Tenbrook Drive, Silver Spring, MD 20901 Catherine Wright Schlosburg, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Demation 5 Other (Specify All Souls Cemetery 04/23/2010 Germantown, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Sign ture / f Funeral Se M00709 1800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between

^enysician/) Medical **Examiner**

Physician/

Medical

10a. State

Director

Funeral

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Completed

Be

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Examiner

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 280 for 200 e.

Certificate: To Be Completed by Physician/Medical Examiner

29b. Signatur

Peraldine

Day, Year)

Tayag

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

	disease or condition resulting in death)	a. <u>Cerebrovascular Accident</u>		Onsot and Boats
	resulting in death)	Due to (or as a consequence of):		
miner	Sequentially list conditions, if any, leading to immediate cause. Liner Unidentified Cause (Disease or linjury	b		
dical Exa	that initiated events resulting in death) Last	c. Due to (or as a consequence of): d.		
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
ted by PI	Part II. Other significant conditions con Hypertension	use contribute to the cause of death?		
Somple			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? Io 1 Yes 2 No
Be (25. Was case referred to medical examiner?	26. Place of Death (Check	only one)	312000
얼	1 ☐ Yes 2 🔀 No	Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hol	me 5 Residence	6 ☐ Other (Specify)
Certificate:	27. Manner of Death 1 🔼 Natural 5 🗌 Pending 2 🗎 Accident Investigation	(Month, Day, Year) injury work? M 1 Yes 2 No	28d. Describe how inju	ry occurred
al Certi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street ar City or Town, State	nd Number or Rural Route Number, e)
Medical	(Check 2 Medical Examin	ician: To the best of my knowledge, death occured at the time, date and place, and ner: On the basis of examination and/or investigation, in my opinion, death occurred at e Practioner: To the best of my knowledge, death occurred at the time, date and place	the time, date and place	e, and due to the cause(s) and manner stated.

D63579

1500 Forest Glen Road, Silver Spring, Maryland 20910

29d. Date signed (Month, Day, Year) April 21, 2010

29c. License number

10+1

State Registrar ed cause of death (Item 23a) (Type, Print)

MD. LLC,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month April 11:40 pm 2010 Carol Sprague Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Rockville Montgomery Casey House Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth **Funeral** 1 □ M 2 🗓 F Months Hours Min Director 219-76-3816 Usual Residence of Decedent or 28a-f show e notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 10d. Inside City Limits Maryland Rockville Montgomery 1 Yes 2 X No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? is marked other than "natural", or items 23a or aumatic event, the Medical Examiner must be Funeral 16605 Winterwoods Court 20853 u.s.A. within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. 1 Never Married 2 X Married ð Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify. Caucasian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Registered Nurse Medical it. Page 1 and 2 should be filed wi rtment of Health and Mental Hygis rtant: If item 27 is marked other njury or other traumatic event, t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Mathews Tantum Gladys Lessia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Steven W. Sprague - Spouse 16605 Winterwoods Court, Rockville, Maryland 20853 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) Parklawn Memorial Pk. 04/22/2010 | Rockville, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 400709 Tarus 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart railure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic Breast Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Physician/Medical Examiner Due to (or as a consequence of): if any, leading to immediate Physician: The law requires that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 X No Day Year 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director, After this certificate I completed filled in by the funeral director, page Yes 2 X No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner?
1 Yes Hospital 2 🗓 No 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice IPU Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number determined Medical 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29d. Date signed (Month. Day. Year) D0070208 April 17, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eliezer Soto, MD. 6001 Muncaster Mill Road, Derwood, Maryland 20855

State

Registrar

31. Date filed (Month, Day, Year)

APR 22 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Helen Odessa Tawney April 18, 2018 7:30 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore County Gilchrist Center for Hospice Care Towson 8. Date of Birth Sep. 7, 1920 Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Funeral Days 1 🗆 M 2 🕱 F 541-12-3426 89 oklanoma Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore County Upperco 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 16541 Trenton Road 21155 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: white 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Smith ပ Melvina Bailey injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Charles Thomas Tawney / husband 16541 Trenton Road Upperco, Maryland 21155 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State April 22 cemetery, crematory or other place)
Christ Lutheran Cem. 1 M Burial 2 Cremation 3 Removal from State Trenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Eline Funeral Home M00741 934 South Main Street Hampstead, Maryland 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician/ COMPLICATIONS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Dun to (or as a nonsequence of) cause. Enter Underlying Cause (Disease or iinjury The law requires that the death certificate be executed physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Day Month i signed by the a 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 🔀 No 3 🗀 Probably 4 🗀 Unknown plnous 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cate has page 2 s performed certificate 2 🗌 No Yes 2 N 1 Tes Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Hospital: 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Yertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number **D64395** 29b. Signature and title of certific WIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 6701 NCHAPLES ST, 8UITE 4105 DANIEUR DOGERMANIMO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Day Roger Lee Vallandingham 2:08A M Apri] 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 27604 Billy Bert Lane Mechanicsville St. Mary's Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours Min. (Month, Day, Year July 24, Mary land 57 Director 212-62-0473 Usual Residence of Decedent 28a-f show ed other than "natural", or items 23a or 28a-f showevent, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2X No Maryland St. Mary's Mechanicsville 10e. Street and Number 10g. Citizen of What Country? Funeral 27604 20659 Billy Bert Lane USA Page 1 and 2 should be filed within 72 hours after death 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 X Married ò ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes, Give Specify: 3 Divorced Completed White Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Auto Body Tech Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Francis Vallandingham Margaret Shirley Nelson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife of Health sitem 27 i Sandra Lee Vallandingham 27604 Billy Bert Lane Mechanicsville, MD 20659 other 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or otl once, Date 20c. Location - City or Town, State Queen of Peace Cemetery April 30, 2010 cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Helen, Maryland permit. Signeture of Funeral Service Mattingley-Gardiner Funeral Home. P.A. P.O. Box 270 Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a conseque ce f) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) sician and burial-transit Exam Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): e attending physician and for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>გ</u> Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 2 🗆 No 1 Yes **Division of Vital** funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at 28a. Date of injury 28d. Describe how injury occurred (Month, Day, Year) 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation

b Hospital or Attending Physician: The law requires that the death certificate be east hours after death.
Panneral Director: After this certificate has been signed by the attending physicia Certificate: Accident completed filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 To the F only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) A

6 State

DHMH 17 Rev 7/2009

30. Name and addre

Jenni**%**r

31. Date filed (Month, 42 7 2 8 2010

40900 Merchants Lane Suite 205 Leonardtown, MD

20650

of person who completed cause of death (Item 23a) (Type, Print)

32. P

Schmidt

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 8:00 p. M April Fred Ky1e Varner, Jr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Mary's 26394 Meadow Road Hollywood If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 D F Months Days Hours (Month, Day, Year) 09/14/1962 West Virginia Director 47 232-13-7403 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland St. Mary's Hollywood 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20636 26394 Meadow Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 K Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced White Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Manager Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Κ. Varner, Sr. Carolyn Morris Fred 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26394 Meadow Rd., Hollywood, MD 20636 Lori Varner/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Brinsfield-Echols 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 04/29/2010 Charlotte Hall, MD 4 Donation 5 Other (Specify) 21. Signer of very Serve and Serve a 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Rd., Leonardtown, MD 20650 M00052 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Hanging Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Cause (Disease or impry that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death the the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 2 🗌 No ပ္

Records, P.O. To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, **Division of Vital**

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred **Subject hanged self.** Unknown 1 Natural 5 Pending 1 ☐ Yes 2 🗶 No 04/24/2010 Investigation Accident P

6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Shed

28f. Location (Street and Number of Bural Route Number, City or Town, State 26394 Meadow Rd., Hollywood, MD

04/26/2010

29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Turse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

only one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year)

D14285

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William D. Boyd, TI M.D. 25365 Point Lookout Rd., Leonardtown, MD 20650

State Registrar

Certificate:

Medical

3 Suicide

4 Homicide

31. Date filed (Month, Day, Year) APR 28 2010

32 Registrar's Signature

3

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		For State Registrar		State	n Maryiai	•	rtificate of L		, ,	erre eg. No. 🤈 🗎	In	11,298	
Physicia Medic		1. Decedent's Name			"				2. Date of Death Month APRIL	2. Date of Death Month Pay Year APRIL 13, 2010 9:4			
Examir		4a. Facility Name (if		give street and nur MORIAL HO			4b. City, Town, o	r Location of Death		K			
Funeral Director		5. Social Security No. 543–32–5	umber	6. Sex 1 X M 2 \square F	7. Age (In yrs. 76	last birthday) Yrs.	If Under 1 Year Months Days	If Under 1 Year If Under 24 Hrs. 8. Date of Birth				place (State or Foreign fry) h Dakota	
A	'n	Usual Residence of 10a. State	Decedent 10b. County		10c. Ci	ity, Town or Lo	cation		pepe: 10			Od. Inside City Limits	
Maryla 28a-f s otified	Director	Maryland	Fred	lerick	Fr	ederic	k				1 √ Yes 2 □ No		
/ith the 23a or st be n	ralD	10e. Street and Nun					10f. Zip Code			10g. Citizen of What Country?			
ems er mu	Funeral	813 Dunb	rooke C	12. Was Dece	edent Ever in U.		2170 Was Decedent of H	ispanic Origin? (Sp	ecify Yes or No-	Jnited S			
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at ance.	by	1 ☐ Never Marri 3 ☐ Widowed		Armed For 1 X Yes If Yes, Giv Year or D	² □ No 19	53-	f Yes, specify Cuba 1 ☐ Yes 2 🔀 No		Rican, etc.)		, White, e	etc.	
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id be filed Mental Hy arked oth atic event	To Be	17. Father's Name (F Arnold B.	, ,	est)				18. Mother's Nam	ne (First, Middle, M , Osman	aiden Surname)			
nd 2 shoul saith and n 27 is m er trauma		19a. Informant's Na Joan M.				19b. Maili 813	ng Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dunbrooke Ct., Frederick, MD 21701						
Page 1 ar nent of He ant: If iter ıry or oth		20a. Method of Disp 1 Derial 2 Donation	X Cremation	3 ☐ Removal from	State	cemetery, crer	esition (Name of matory or other place n Cremato	· · · · · · · · · · · · · · · · · · ·	1 15,	oc. Location - C		wn, State faryland	
permit. Departr Importa any inju		21. Signature of Ear	ieral Service Li	censee		Ŕ	. Name and Addres	s of Facility Funeral	Services	Skkot	Cody		
Physician/		Immediate Cause (I	of failure. List of Final	omplications that only one cause on ea	caused the dear	th. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arres	t,		Approximate Interval Between	
Medical Examiner		disease or condition resulting in death)		a. Due to	(or as a conseq	uence of):	2-mic	1100/	1001.4	7			
ited	Examiner	Sequentially list cor if any, leading to im cause. Enter Under Cause (Disease or i	nmediate rlying iinjury	b. Due to	or as a conseq	uence of):							
ath certificate be executed attending physician and for use as the burial-transit	<u></u>	that initiated events resulting in death) L		Due to	or as a conseq	uence of):							
tificate ng phy as the	Med	IF FEMALE:		u						1			
to the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Luneral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medic	23b. Was decedent in the past 12 n 1 Yes 2 9 Unknown	months?	1 🔲 Live	nant at time of	aldeath 3 □	Ectopic pregnand Other (specify)	у		23d. Date Mont	ry Day Year		
To the Hospital or Attending Physician: The law requires that the dewithin 24 hours after death. To the Funeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.		Part II. Other signifi	icant condition	s contributing to d	eath but not re	sulting in the u	nderlying cause giv	ren in Part I.				e cause of death?	
he law req te has bee age 2 shoບ	Completed by								24a. Was an autopsy perform	ed? de	ior to con ath?	sy findings available npletion of cause of	
ilan: Ti artificat ctor, pa	Be C	25. Was case referre examiner?	ed to medical				26. Pla	ace of Death (Chec	1 ☐ Yes 2 k only one)	No 1	Yes 2	2 🖾 No	
Physic this ce al dire	မ	1 Yes 2 2			Inpatient 2			4 ☐ Nursing Ho	ome 5 Resider				
tending F feath. tor: After the funer	Certificate:	1 Natural 2 Accident 3 Suicide	5 Pending Investiga 6 Could n	ation	th, Day, Year)	28b. Time of injury	work M 1 □	rat ? Yes 2 □ No	28d. Describe how	/ injury occurred			
intal or At urs after c ral Direct lled in by		4 Homicide	determir	ned 28e. Place buildi	ng, etc. (Specify	y) 	eet, factory, office		28f. Location (Stre City or Town,	State)			
the Hosp hin 24 hor the Fune upleted fi	Medical	(Check 2 only one) 3	 ✓ Medical Ex ✓ Certifying I 	aminer: On the bas	is of examinatio	n and/or inves	leath occurred at the	n, death occurred a e time, date and place	t the time, date and	place, and due t	o the caus	se(s) and manner stated.	
viti To		29b. Signature and t	m M	(ORe	ndl	2 n	29c. License	number 4344	13 29	d. Date signed (ay, Year)	
		30. Name and addre		no completed caus	e of death (Iten		•	ederick.	MDSIT	101			
Stat Registra	e	31. Date filed (Month			egistrar's Signa	ture	ball						
					/		-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 11.45AM ames 2010 4a. Facility Name (If not institution, give street and number, County of Death **Baltimore City** The Johns Hopkins Hospital Baltimore City If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Months Days Hours Min. Jan. 18,1943 Birthplace (State or Foreign Country) 5. Social Security Number . Age (In yrs. last birthday) 1 XM 2 □ F 215-42-4250 Maryland 67 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2X No Maugansville Maryland Washington County 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 13902 Green Mountain Dr. 21767 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 1961 - Year or Dates: 1963 14. Race - American Indian, 11. Marital Status 1 Never Married 2 X Married Specify: White 1 ☐ Yes 2 🔀 No Specify 3 ☐ Widowed 4 ☐ Divorced 1963 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Machinist Building Product Mfg. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Catherine McGuire Weddle Harry S. Weddle, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13902 Green Mountain Dr. Maugansville, MD 21767 Georgia Weddle-wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory 4-27-2010 Smithsburg, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Lige 1331 Eastern Blvd. North Hagerstown, MD 21742 Kartlin 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respirator Failure disease or condition resulting in death) umon 10 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown 23e. Did tohacco use contribute to the cause of death?

Hospital or Attending Physician: The law requires that the death certificate be executed physician and street the burial-t Division of Vital Records, P.O. Box 68760. the by nin 24 hours a the Funeral D mpletely filled

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Completed

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Physician/Medical

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Medical Certification:

Funeral

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28a-f show

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items 23a

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th and Mental Hygiene.
It is marked other than "natur traumatic event, the Medical

Department of Health a Important: If item 27 is any injury or other tra

Physician

/Medical Examiner

must be notified

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

art ii. Other significant c	onditions co	intributing to death but not re-	salang in the under	, mg oac	oo giroii iiri airii		LOC. Did tobacco de					
		•					1 🗆 Yes 2	No 3 Probably 4 Unknown				
							24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No				
5. Was case referred to n	nedical				26. Place of De	ath (C	heck only one)					
examiner? 1 ☐ Yes 2 X No		Asspital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)										
	Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M		Injury at Work? 1 ☐ Yes 2 ☐ No	280	d. Describe how injury	occurred				
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		rsician: To the best of my kno iner: On the basis of examina						and manner as stated. place, and due to the cause(s)				

29c. License number

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within 2 To the I

who completed cause of death (Item 23a) (Type, Print) and address of pers ustavortou HILLASEI

M.D.

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

2010

State Registrar

31. Date filed (Month, Day, Year) APR 2

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 4:35 PMM Alexander Mitchell May 010 Bernice Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 15336 Beaufort Place Silver Spring g. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Ye Oct. 16, 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 □ M 2 🖾 F Hours 1914Director 434-62-3948 Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Silver Spring MD Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20905 15336 Beaufort Place Page 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
ant. If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Rebecca Watson Calvin Mitchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20905 15336 Beaufort Place, Silver Spring, MD Bernice Bennett/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 🖾 Burial 2 🗆 Cremation 3 🗀 Removal from State 5-8-10 Metairie, LA 4 Donation 5 Other (Specify) Providence Cemetery Rhodes Funeral Home 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility 70125 3933 Washington Avenue, New Orleans, LA aft 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart fallure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final Physician/ metastatic cancel DIMALY disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine cause. Enter Underlying Cause (Disease or linjury Due to for sels consequence un been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by thombosis Deep venous 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29d. Date signed (Month, Day, Year) D0057244 05 MD

State Registrar 31. Date filed (Month, Day, Year)

MISCONSIN

CHEVY CHASE

mo 20815

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regi trar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 05-05-2070 **Physician** Noretta Gladys Ahrens 11:20 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford 329 North Earlton Road Havre de Grace If Under 1 Year | If Under 24 Hrs. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Maserrend 68 213-38-761 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Western Experiment as 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director Maryland Herford Havre de Grace 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21078 United States of America 329 North Earlton Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 specify: White 1 ☐Yes 2 No Specify. <u>۾</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerical Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eddie 0. Ishbaugh Ida L. Hickok ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Jown, State, Zin Code) 329 North Earlton Road, Havre de Grace, Maryland 21078 19a. Informant's Name/Relationship (Type. Print) Ralph A. Ahrens, III 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomety Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 🖾 Burial 2 ☐ Cremation 3 ☐ Removal from State 05-12-2010 Grant Township, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Zellman Funeral Home, 123 S Washington St, Havre de Grace, Maryland 21078 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on a ch line. Immediate Cause (Final **Physician** 4C47 disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transi resulting in death) Last Due to (or as a consequence of): Box 68760. physician Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 mon jo Month Day Year signed by the a 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1. Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has b autopsy perform certificate 1 ☐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? 2 Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To funeral To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral 27. anner of ath 28a. Date of Injury (Month, Day, Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 2 ccident 5 Pending investigation 1 ☐ Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of pertific 29c. License number 29d. Date signed (Month, Day, Year) MON OF 2010 30. Name and address of berson who completed cause of death (Item 23a) (Type, Print) University of Mary wind Greener min Carcer conterns Edelman, M.D. Macky 22 3 Greene St Baltimore MD21221 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 05 ROBERT, F., BATEMAN 06:45 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel 8. Date of Birth (Month, Day, Year) Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Hours Min. Maryland Director 214-40-7847 68 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland | Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21144 United States 428 Burns Crossing 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Completed by 1 Never Married 2 😾 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: "natural", 3 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Forman Nevamar Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert T. Bateman Anna M. Bull 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Severn, MD Dorothy Bateman / Wife 428 Burns Crossing, 1 Dispurial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o Ponation 5 Other (Specify) Glen Haven Mem. Park 5/10/2010 Glen Burnie, Maryland 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home, P.A.
421 Crain Hwy. SE; Glen Burnie, MD 21. Signal ide Licen e 21061 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ CONGESTIVE HEART FAILURE disease or condition resulting in death) Medical Examiner OROMARY Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month 9 Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSION CHRONIC LYMPHOCYTIC Completed 1 ☐ Yes 2 ☐ No 3 🗷 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe 124 hours after death.

Funeral Director: After this certificate I leted filled in by the funeral director, pagr 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 Inpatient 2 ER/Outpatient 3 IDOA Certificate: 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis or examination allows investigation, in this opening, south a state and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 Markeykun, MD 05,06,2010

Registrar
DHMH 17 Rev 7/2009

10

N. CRAIN

HWY BA BLENBURNIE MD 21061

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARK KIM, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician/ Brown Sr. 05 2010 Larry
4a. Facility Name (if not institution, give street and number) Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Anna Arundel Glen Burnie Baltimore Washington Med. Cente 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 1**火** M 2 □ F Months Hours 61 49 Director MD 214-52-8195 Usual Residence of Deceden iral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Severna Park 1 Yes 2 No MDAnna Arundel 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 21146 U.S.A. 334 Baltimore Annapolis Blvd Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian. Black, White, etc. 1 Yes 2 No 1 Never Married 2X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Steamship Trade Longshorman 2th grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Lola E. Peterson Timothy Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 7646 Hennesey Ct., Glen Burnie, Md 21061 Larry Brown Jr.-Son 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of 20c. Location - City or Town, State lst Baptist Church 5/13/10 any injury or Glen Burnie, Md 21. Signatur of Funeral Service License March F/H West 4300 Wabash Ave, Baltimore, 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. The death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death CARDIO PUL Priysician/ MONARY disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Hospital or Attending Physician: The law requires that the death certificate be execute attending physician and for use as the burial-trar that initiated events resulting in death) Last Physician/Medical FIBRILLATION Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Year Pregnant at time of death signed by the a d be detached f 2 🗌 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ TASTATIC LUNG CANCER 1 Yes cate has been signage 2 should b 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed certificate 1 Yes 2 No director, æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မြ 1 Inpatient 2 ER/Outpatient 3 I DOA this al Director: After this ed in by the funeral d 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Direct completed filled in by Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Pertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 9b. Signa 29c. License number

DHMH 17 Rev 7/2009

State Registrar

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who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-03440 State of Maryland / Department of Health and Mental Hygiene Dawn Louise Breckenridge Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month 0830 hrs Dawn Breckenridge May 4, 2010 Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Allegany Flintstone I 68 @ 52 mile marker If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director 02/13/1964 PA Country) 46 1 M 2 XF Yrs 178-62-9197 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City. Town or Location uny 1 Yes 2 No or 28a-f show Fayette City Fayette death with the Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 1119 Connellsville Road Funeral 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 2 X No Yes White 5 1 Yes 2 No specify: Specify 3 X Widowed Divorced If Yes, Give Year Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner. à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jane Sturgis Donald Breckenridge 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ဥ 451 Marine Street, Belle Vernon, PA 15012 Larry Breckenridge, Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery crematory or other place) Date 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Mon Valley Cremation Service 05/08/2010 | Belle Vermon, PA 4 Donation 5 Other Specify: 22. Name and Address of Facility Schrock-Rogan Funeral Tiome Service Licensee 226 Fallowfield Ave, Charleroi, PA 15022 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line (Medica Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, iner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit hysician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, 23d, Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ā ð Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25 Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene 1 🗸 Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) May 4, 2010 28c. Injury at Work? Manner of Death 28b. Time of Injury Certification: Occupant auto fixed object collision 0816 hrs 1 Natural 1 Yes 2 V No Pending 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Suicide Could not be or Town, State) I 68 @ 52 mile marker, Flintsone, MD determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) §ignature and title of certifie 29b. May 5, 2010

Registra DHMH 17 Rev 1/2001 **OCME 2006**

State

ORIGINAL

ne youll

Assistant Medical Examiner

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

Oraberte

Margarita Korell MD.

31. Date filed (Month, Day, Year,

OCME

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2010 14305 State of Maryland / Department of Health and Mental Hygiene John Butcher 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month 0830 hrs **Medical Examiner** May 4, 2010 John Butcher 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death I-68 at Mile Marker 52 Flintstone Allegany 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Days Hours Director 209-62-0410 42 Country) 1 X M 2 F 02/17/1968 PA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State s 23a or 28a-f show a e notified at once. PΔ 1 XYes 2 No Fayette Fayette City permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mortal Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 109 Navaho Hollow Road 15438 USA Funeral 11 Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes Specify: White 1 Yes 2 X No specify. 4 X Divorced If Yes, Give Year ð 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Technician Solar Energy 17. Father's Name (First, Middle, Last 18.Mother's Name (First, Middle, Maiden Surname) Wallace Butcher Charlene Simmons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlene Butcher, Mother 109 Navaho Hollow Road, Fayette City, PA 154

20c. Location - City or Town, State PA 15438 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 1 XBurial 2 Cremation 3 Removal from State Belle Vernon Cemetery 05/08/2010 Belle Vernon, PA 4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility T. Harman Leonard J. Parzynski FH 626 Broad Avenue, Belle Vernon, PA15012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last hysician/Medical UNPENDED **AMENDED** ed by the attending physician detached for use as the burial Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d, Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Dav Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown P.O. 立 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ⋧ 1 Yes 2 No 3 Probably 4 Unknown Completed Records. 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed death? 1 🗸 Yes page ✓ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) of Vital Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other Scene this 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) FOUND: 28d. Describe how injury occurred After 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury Ejected occupant in auto collision FOUND: Natural 1 Yes 2 ✓ No the Pending May 4, 2010 0812 hrs 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) I-68 at Mile Marker 52, Flintstone, MD determined 24 hours a (Specify) Interstate Homicide 29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. one)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s). ical To the 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E. May 5, 2010 a 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Carol Allan, MD 111 Penn Street, Baltimore, MD 21201 31. Date filed (Mont), Registrar's Signatur Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 ar May Physician/ 2:10 P Theresa Boia Mary 5, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Middle River Baltimore Woodlands Assisted Living Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 219-18-4490 88 Ohio Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 X Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21224 with Funeral 626 Rappolla Street U.S.A. 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forces ☐ Yes 2 🛛 No þ 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White "natural", Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) C & P Telephone Secretary marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Theresa Leabu Boia and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl ment of Health a ant: If item 27 i Diane Coughlin - Godchild 7849 Wynbrook Road Baltimore, Md. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of H Important: If ite injury or 1 X Burial 2 Cremation 3 Removal from State Oak Lawn Cemetery 5-8-2010 4 Donation 5 Other (Specify) Baltimore, Maryland 21. Signat Funeral Service Lice 22. Name and Address of Facility Joseph N. Zannino Jr. F.H. any 263 S. Conkling Street Balto. Md. 21224 e, or c. implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List of yone cause on each line. 23a. Part 1. Enter the diser shock, or heart faild Approximate Interval Between onset and Death Immediate Cause (Final) Acute Cardiopulminary & Respriatory Failure Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner weeks Urinary tract infection Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). Examir years that the death certificate be executed Hypertension & Arrythymia physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical years Atrial fibrillation Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 X No
9 Unknown Month Pregnant at time of death g Unknown P.O. | ed by t s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Hospital or Attending Physician, The law requires Dysphagia, pacemaker, anemia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Peripheral vascular disease 24a. Was an page 2 nas autopsy performed' certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 🖾 No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral director and the funeral directors. this living 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 \square Pending 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 30. Name and address of person who completed cause of death (item)

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32. Regig

TOX

Allen Reilly M.D.

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

House

D-54749

May 6,

Ave D-1 Frederick, Md 21701

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 2010 Physician/ Month 23.35 pm Rosaria D'Anna Barbera Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death JU15129 De Haure race Har 01 Citizens Home If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 6. Sex . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Aug 11, 1923 1 □ M 2 🕱 F Maryland Director 216-14-8713 86 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Harford Belcamp 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 4302 Foxglove Ct 21017 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 Yes If Yes, Give 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 X Widowed 4 ☐ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Finance Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frances (nmn) D'Anna Concetta (nmn) D'Angelo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanette B. Rafetto Daughter 4302 Foxqlove Ct., Belcamp, MD 21017 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ation 3 🗌 Re 1 🔀 Burial 2 🗌 Cren onation 5 🔯 Other (Specify) Most Holy Redeemer 5-6-10 Baltimore, Maryland 21. Sign at re of Fun 22 Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd. Abingdon art 1. Enter the disease, or complications that cau hock, or heart failure. List only one cause on each sed the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or the attending physician and the for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: been signed by the attendin should be detached for use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Ectopic pregnancy Month Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by law requires Records, 4 Unknown 2 No 3 Probably 24a. Was an Were autopsy findings available prior to completion of cause of this certificate has autopsy performed? death? The 2 1 No 1 🗌 Yes within 24 hours after death.

To the Funeral Director. After this certifics completed filled in by the funeral director. I Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner eath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending atural 5 Pending Division 1 ☐ Yes 2 ☐ No Investigation Could not be Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 and title of certifier 29b. Signature 29d. Date signed, (Month, Day, Year) 4110 M. 1) Name and address of person who completed cause of death (Item 23a) (Type, Print) MO

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year

2

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** CARRIERE, 21.08 PM JOHN A. 29-2010 APRIL /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HAVEDES METOUTE HARFORD HOSDITAL HAVRE OF GLACE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 0 1 - 0 9 - 1 9 3 Social Security Number 9. Birthplace (State or Foreign County) New York 7. Age (In yrs. last birthday) **Funeral** 1∭M 2□F 102-24-6587 79 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Harford Havre de Grace 1 XYes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 510 Commerce Street 21078 United States of America Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 1 NYes 2 No If Yes, Give Year or Dates: 1957 - 59 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Obstetrician/ Gynecologist Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fil ment of Health and Mental H sent: If Item 27 le marked ott Albert G. Carriere Ila Almaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John A. Carriere Jr. (son) 708 Chesapeake Drive, Havre de Grace, Maryland 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 05-04-2010 Havre de Grace, Maryland permit. Page Department of Importent: If any Injury or once. Mt. Erin Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Zellman Funeral Home. P.A. 21. Signature of Fun 123 S Washington St, Havre de Grace, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PNELMONIA **Physician** 2 WEEKS /Medical Due to (or as a consequence of) Examiner CAN CER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury burial-transit resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part Jl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PULLEDNARY & TOCOLLIS MoLLITUS 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? If YPELGENTION, CORONALY 24a. Was an autopsy performed? ATMIAL FIRRILLATION 0150ASG 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 **X**No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Medicai Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident the Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Direct completely filled in by 4 Homicide 1 (Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

Division of Vital Records, P.O.

DHMH 17 Rev 1/2001

HARFORD MOTORIA

32. Regis ar's Signature

30. Name and/address of person who completed cause of death (Item 23a) (Type, Print)

AUN SWEATTON

31. Date filed (Month, Day, Year)

ARKIC. 70.2010

HOPPITAL, HAURE DE GLACE 21078

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 0726 AM Isabelie Mac 2010 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) 4c. County of Death Baltimone Johns. Hopking Bayries Wadical Coefer 5. Social Security Number 6. Sex 7. Age fin yrs. last birthda 9. Birthplace (State or Foreign Country) 14 Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) 1 □ M 2 🖺 F Months Days Hours September 2,1914 212-10-7006 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Balto. Kingsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 700 Karen Drive 21087 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 □Yes 2 No Specify: White Specify. 3 N Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Clothing Manufacturer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Janicki Felix Pruski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR. 700 Karen Drive Kingsville, Md. 21087 Sharon Jones 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 5-8-2010 Balto. Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ardio Kespivatovu disease or condition resulting in death) Due to (or as a consequence of): 23d. Date of delivery Month Day Year co use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No No

Physician /Medical Examine

Physician

Examiner

Funeral

Director

ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be molified at

of Health and Mental Hygie item 27 is marked other other traumatic event, It

Department of H Important: If iter any Injury or oth once.

Funeral Director

Completed by

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

10a. State

Md.

the burial-transi After this certificate has been sign funeral director, page 2 should be n 24 hours after death.

e Funeral Director: Af etely filled in by the fur

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if any leading of immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		2 da				
IF FEMALE: 23b. Was decedent pregnant	Due to (or as a conse d. 23c. If yes, outcome of pregi				23d. Date of de	slivery
in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown				Month	Day Ye
Part II. Other significant conditions	contributing to death but not re	sulting in the underlying ca	use given in Part I.		24b. Were a prior to death?	o the cause of dea Probably 4 Un utopsy findings av completion of causes 2 No
25. Was case referred to medical examiner?			26. Place of D	eath (Check only one)		
1 Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatient 3 ☐ DC	A Other: 4 ☐ Nursing	Home 5 ☐ Residence	e 6 □Other (Spe	ecify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)		3c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how		
3 Suicide 6 Could not determined	28e. Place of Injury - At building, etc. (Spec	nome, farm, street, factory	office	28f. Location (Stree City or Town, S	et and Number or R State)	tural Route Numb
	se(s) and manner a and place, and du					
29b. Signature and title of certifier	D ms		License number	29d.	Date signed (Mon	th, Day, Year)

State Registrar

TTA 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



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-	Examin		4a. Facility Name (if not institu		et and number)			4b. Ci	ty, Town, or				4c. County of Dea Ba1			
	Funeral		Stella Maris 5. Social Security Number	6. Sex	7. Aq	Timonium 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.					8. Date of Bir	th			e (State or Foreign	
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	with th	Funeral Director	1002 "A" Do	ormina	Count			101.	210	1 /				SA	ountry:	
	eath v	F.	11. Marital Status		. Was Decedent I	Ever in U.S	. 13	. Was Dec			Origin? (Sp	ecify Yes or No- Rican, etc.)		14. Race - An		ndian,
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Baltimore, Maryland 21215-0036	permit. Page Department of Important: If any injury or once.		21. Sign ture of Funeral Serv	ice Licensee) ,				and Addres			chimunel				
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Division of Vital Records,	or Attending Physician: The law requires that the death certificate be after death. Director: After this certificate has been signed by the attending physic in by the funeral director, page 2 should be detached for use as the b	Completed										24a. Was auto		24b. Were a prior to death'	o comple	findings available etion of ca <i>u</i> se of
Ä	ding Physician: The law h. After this certificate has funeral director, page 2 v		25. Was case referred to med	ical					00 DI			1 Tes	2 X	lo 1 🗆 Y	es 2 [No
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	To the within To the comple		29b. Signature and title of cer	tifie 7				2	9c. License	numbe	· ~ ~	.		ate signed (Mor		Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 6 9:25 Α Caste1 Christopher May Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Timonium Baltimore County <u>Stella Maris Hospice</u> Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Days Hours Min. California Director 215 64 2851 Yrs Tune 6. Usual Residence of Decedent or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2X No Glen Burnie Maryland | Anne Arundel 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21061 United States 450 Phirne Ct. East 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ "natural", or 1 X Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 Yes 2 X No Specify Specify: Completed 3 Divorced 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Education 12 Custodian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည should be Joan Alexander Dennis Castel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD Page 1 and 2 4333 Berger Ave. Michael Schirmer / Brother in law 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State □ĮBurial 2 XCremation 3 □ Removal from State 5/11/2010 4 Donation 5 Other (Specify) Metro Crematory Catonsville, MD 21. Sign re of Kun eral Sen e Licens Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy. SE; Glen Burnie, MD 21061 inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) CEREBROVASCULAR ACCIDENT Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death Yes 2 No by the 9 Unknown 9 Unknown Records, P.O. signed t Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 X 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: After this certifica eted filled in by the funeral director, I 25. Was case referred to medical **Division of Vital** æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 2 X No ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29 c. License number 29d. Date signed (Month, Day, Year) son who completed cause of death (Item 23a) (Type, Print) 30. Name and address of per

DHMH 17 Rev 7/2009

State Registrar HAUF,

31. Date filed (Month, Day

CRNP

CASTEL

CHRISTOPHER

VALLEY RD.

TIMONIUM, MD 21093

2300 DULANEY

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #1, per MD g903 5/7/10 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 150 PM **Ernest Cheatom** 2010 Mar Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Bayview Medical Center Baltimore 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month Day Year) 1940 **Director** 220-36-0194 69 SC Usual Residence of Decedent 28a-f shov 10b. County 10a. State at 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits Not overd Mental Hygiene.
marked other than "natural", or items 23a or 28a-r sr
marked other than "natural", or items 23a or 28a-r sr
marked other than "natical Examiner must be notified? MD 1 X Yes 2 No BALTIMORE DUNDALK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1612 MELBOURNE RD 21222 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced Year or Dates BLACK permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 PARCEL CLERK FOOD INDUSTRY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ ORA CHEATOM ALBERTA SIMPSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HESTER CHEATOM/WIFE BALTIMORE, MD <u>1612 MELBOURNE RD.</u> 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ST. STANISLAUS CEM. 5/12/2010 BALTIMORE, MD Signature of Funeral Service Licenses 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, Approximate Interval Between Onset and Deat 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ colon disease or condition resulting in death) metastatic cancer o months Medical Due to (or as a consequence of) Examiner Secuentially list nonditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🖪 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat Funeral Director: 3 Suiciae 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the I only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed of Avenue Baltimore, MD, 21224 4940 Michae 31. Date filed (Month, Day, Year) 32. Registra s Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MAY 9:15 P M 4 2010 **EVELYN** COMBS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** KESWICK MULTI-CARE CENTER BALTIMORE . Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🗶 F Months Days Hours 01/05/1924 **Director** 216-20-9329 86 MD Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Me Ical Ex miner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director XX Yes 2 No BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21218 928 CATOR AVENUE USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 🗆 Yes 🛣 No Specify: Specify: BLACK If Yes Give Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) **CLERK** U.S. GOVT 12 Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) မ RUBY HAWKINS **JOHN** HAWKINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 928 CATOR AVENUE, BALTO., MD 21218 FLOYD COMBS/HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 05/11/2010 | TRIANGLE, VA QUANTICO NAT. CEM. Signature of Funeral Service Licenses 22. Name and Address of Facility JAMES A. MORTON & SONS F.H, INC 1701 LAURENS ST. BALTIMORE, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between On e and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due o (or as a consequence of) Examiner pes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗌 Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 ☐ No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending 1 Tes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar (Check

only one) Signature and title of

Date filed (Month, Day,

address of person who completed cause of death

(Item 23a) (Type, Print) 6701

32. Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month v 2 Jeanette Callaway 2010 РМ May 4:29 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1. 🗆 M 2 🗓 F ^{Year)} 195<u>4</u> Nov. 13 Virginia Director 228-80-2605 55 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 Yes 2 No MD Prince Georges Hyattsville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20782 4922 LaSalle Road USA "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14. Bace - American Indian. Completed by 1 Never Married 2 Married 1 Yes 2 K No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black 3 ☑ Widowed 4 ☐ Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than College (1-4 or 5+) Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha 12 Howard University Executive Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James H. Arnold Sarah V. Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 156 Hawthorne Drive, Newport News, VA 23602 Shirley W. Cheeseman/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Roosevelt Cemetery injury May 7,2010 Chesapeake, VA 4 Denation 5 Other (Specify) ²² Name and Address of Facility Pretiow & Sons Funeral Home 500 Liberty St., Chesapeake, 21. Sign ture of Funeral Service L VA 23324 name 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and that initiated events Due to resulting in death) Last cate has been signed by the attending physician page 2 should be detached for use as the hinfall Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an certificate has I autopsy performed? Yes 2 X No 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital မ Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending 2 🗆 No Accident Investigation 24 hours after death Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed-(Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regist

's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 25,27,28a-f per me, 2903,05/07/2010dhb

Certificate of Death

Reg, No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Louise M. Cheshire 240 A 03-27-2010 Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Lorien Bel Air Harford 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 M 2 T 03-26-1923 Director 235-32-7193 87 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No MD Harford Fallston 10e. Street and Number permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be. 10f. Zip Code 10g. Citizen of What Country? Funeral 2501 Claret Drive 21047 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces?
1 ☐ Yes 2 🗓 No þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Specify: White 3 X Widowed 4 □ Divorced Completed Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry Je filed with... Hal Hygiene. Se**r than "r** (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Stanley R. Cheshire Ada Nealis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Russell S. Cheshire (Son) 2501 Claret Drive Fallston, MD 21047 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HOlly Hill Cemetery 03-30-2010 Baltimore, MD Fu eral Servi 22. Name and Address of Facility Schimunek Funeral Home of Signatura BelAir Inc 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physicianz disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). KOTTON APPROVED BY MEDICAL EXAMINER attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical CERT IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant
g ☐ Unknown been signed by the sahould be detached Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has ; page 2 s autopsy performed? After this certificate Yes 2 🗆 No Division of Vital 26. Place of Death (Check only one) Be examiner: Hospital: Other: 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA 욘 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: the Hospital or Attending I thin 24 hours after death. the Funeral Director, After Unknown M work? 5 Pending 2 X Accident Natural 02/26/2010 Subject fell Investigation 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office Assisted Civing Facility 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1919 Emmorton Road Bel Air, MD io the ta. within 24 hours *he Funeral Direa determined Medical 29a. Certifier Certifying Physiciany To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nuise Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 [29b. Signature and title of certifie 29d. Date signed (Month, Day, Year, D004 2304 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -IAN

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year,

Registrar's Signature

10-03384	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

юзерп	Richard		1- For State Registrar		e of Marylar	-	ertificate o			ivientai i	Hygiene	Reg. I	20		1:31
Medica	Physici al Exam		1. Decedent's Nam	ne (First, Middle,La oh Richa	•	pinti	eri. S	r			2. Date of Month May 2	Da	ay Year		3. Time of Death 2123 hrs
1			4a. Facility Name ((if not institution, g				4b. City,	Town, or Lo	ocation of Dea		2010		Death	
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	any		Usual Residence of 10a. State	10b. County		10c. City	y, Town or Locat	ion							10d. Inside City Limits
	land f show	5	MD												1 X Yes 2 No
	he Mary or 28a- ified at	Director	10e. Street and Nu 1420 St	_{umber} t. Michae	el Court				040			10g.	Citizen of Wha	it Coun	try?
	Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Marri	ied 2 Marrie	12. Was Deced		J.S. 13. Wa	s Deced	ent of Hispa	anic Origin? (Mexican, Puer	rigin? (Specify Yes or No-			14. Race - American Indian, Black,	
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21215-0036	uld be filed withi Mental Hygiene, marked other tl	Be Co	17. Father's Name	(First, Middle, Las h Carpint	•				18		ne (First, Midd	2010 4c. County of Death Harford 5creaty Jand 10d. Inside City Limits 1			
212	hould b nd Men is marl atic eve	To E	19a. Informant's Na	ame/Relationship (Type, Print)		19b. Mailing	Addres	s (Street a	seet and Number or Bural Bouto Number. City or Town State. 7in Code)					
₹.	permit. Pages 1 and 2 shoul Department of Health and M Important: If item 27 is m injury or other traumatic		Angela Ca 20a. Method of Dis		:1-daught	20b.	Place of Dispos	ition (Na	me of ceme	tery,	Date	Park 20	c. Location - C	Mary	y Land
Baltimore, MD	Pages l nent of l ant: If			Cremation 3 Other Specifi		State Ev	rematory or other ans Fundans and Cremat	erplace eral ion S) Chap	el Mar	y 12,20	010	Fores	tн	ill,MD
Balti	permit. Departn Import, injury		21. Signature of Fu	ineral Service Lice	nsee 1c 1		22. N	lame and	Address of	Facility	pel an	d Cr	ematio	n Şe	ervices
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9289	eath certificate attending phy for use as the l	an/M	IF FEMALE: 23b. Was decedent past 12 months		23c. If yes, out	h	2 Fet	tal death	3	Ectopic pregr	nancy	1		-	ay Year
Records, P.O. Box 68760,	death or he attend d for use	Physician/Medical Examine	1 Yes 2 N	No 9 Unknow		nt at time of de	eath 5 Oth	ner (Spe	cify)						
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of V	tending Physician: eath. tor: After this certifi the funeral director,	입	27. Manner of Deatl	2 No	28a. Date of	Injury	ER/Outpatient 28b. Time of Ir		28c. Injury a			be how i	njury occurred		Scene
sion	Attendi death. ector: / by the fi	catio	1 Natural 2 Accident	5 Pending Investigat		10	FOUND: 2123 hrs			2 🗸 No					
Divi	pital or At ours after d ieral Direct filled in by	Certification:	3 Suicide 4 Homicide	6 Could not determine	De		ome, farm, stree	t, factory	, office build	ding, etc.	or Tow	n, State)			
D -	To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the			Certifying Physic Medical Examine											
-	For With	Medical	29b. Signature and		and manner state					opinion, death occurred at the time, date an			I. Date signed		
()	<i>(</i>)		are	LC:					O.C.M.I	E.		M	May 3, 2010		
10	3		30. Name and addre Ana Rubio N	·	completed cause ont Medical Ex	,	^{23a)} 111 Penn S	treet, E	Baltimore	, MD 2120	1				
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			1 – For State Registrar	State of M		ertificate of			eg. No.	4317			
			Decedent's Name (First, Mi	iddle, Last)				2. Date of Deat	2. Date of Death 3. Time of Death				
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and the second	/Medi Examir		4a. Facility Name (If not institu)	4b. City, Town, o	or Location of Death		ath				
-			Good Samarita	n Hospital		Baltimo	re			N/A			
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	the Marylar 28a-f show	ţò	Maryland Balt	imore County	Baltimore					1 □Yes 2 K No			
	or 28	irec	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	ountry?			
	23a ust b	Funeral Director	1204 Brixton Road	<u>f</u>			39–1218		United Sta	ates			
	er deg	nue	11. Marital Status	12. Was Decedent Armed Forces' Married 1 □ Yes 24	Ever in U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whit				
36	rs afte		1 ☐ Never Married 2 ♣ N	If Vas Giva	No	1 □Yes 2 No	Specify:		Specify:	White			
9	72 hours after death with the Maryland natural", or items 23a or 28a-f show item Examinat be realthed at	Completed by	15. Dece	dent's Education	16a. Dece	edent's Usual Occu	pation		16b. Kind of Business	/Industry			
215	hin 73 e. an "n	ble	(Specify only hig Elementary/Secondary (0-1)	phest grade completed) 2) College (1-4or	(Give	e kind of work done DO NOT use retire	during most of work	ing					
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nd	be file	To Be	17. Father's Name (First, Midd Winford Boyd Carr				18. Mother's Name Neva Jack	_	Maiden Surname)				
3	ould d Mer narke	မှ											
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any njury or other traumatic event, the Wedford Exaction from the motified at once.		19a. Informant's Name/Relation Mrs. Barbara Ann		٠	-	d Baltimore,		; City or Town, State, 21239–1218				
<u>ئ</u>	Heal		20a. Method of Disposition	(-,,,,,,,,	20b. Place of Disponentery, cre				20c. Location - City or	Town, State			
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687	tifical ng phy as th	Physician/Medical											
Box	th cer rendir	N/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		☐ Ectopic pregnan	CV.		23d. Date of de	•			
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<u>a</u>	in: The ifficate or, par		25. Was case referred to med	ical			00 DI (D II	1 □ Yes 2	2 🗹 No 1 ☐ Ye	s 2 MNo			
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10	ding Phys h. After this funeral dir	ë	27. Manner of Death	28a. Date of Inj	ury 28b. Time o	of 28c. Inju	iry at		ow injury occurred	eury			
<u>5</u>	endin ath. or: Af he fur	atio	Z L Modidont	estigation	19, 1047		Yes 2□No						
Division of Vital Records,	r Atto	Certification: To		ald not be ermined 28e. Place of In building, e	jury - At home, farm, st c. <i>(Specify)</i>	reet, factory, office		28f. Location (St. City or Town	reet and Number or F o, State)	Rural Route Number,			
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certin (Check only one) 2 Medic	fying Physician: To the best cal Examiner: On the basis and manner si	of examination and/or i	th occurred at the t nvestigation, in my	time, date and place, opinion, death occur	and due to the c red at the time, d	ause(s) and manner a ate and place, and du	as stated. le to the cause(s)			
	othe othe	Mec	29b. Signature and title of cert		ateu.	29c. Licen	se number	2	9d. Date signed (Mon	th, Day, Year)			
	F S F O		A. Kar	unakou.	MD	RE	5-000		05/04/	10			
			30. Name and address of pers	on who completed cause of	death (Item 23a) (Type,	, , , ,			- / /				
_			KARUNAKAR	AKASAPU		*	Boulevard	,Baltimo	ore Maryla	nd 21239			
	Sta		31. Date filed (Month, Day, Ye		rar's Signature								
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ORIGINAL

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		Registrar	19State of M	-,,,,,,	Cer	tificate of	Death		Reg. N	0010	1.31	
Physicia Medic		Decedent's Name (First, Middle, JOHN	Last)			CARTEF	2	2. Date of D Month MAY		3°, 20°f°	3. Time of Death 8:10 A	
Examin		4 5 100 11 700 11 10 11					4b. City, Town, or Location of Death FOREST HILL			4c. County of Death		
Funeral Director		5. Social Security Number 218-40-7579			st birthday)	FOREST HILL HARFORD					hplace (State or Foreig	
show dat	ا اق	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	ation					10d. Inside City Limit	
popur. Tage I and 2 Should be line within 72 hours after bearn with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	irect		timore	1	Middle	River		1 □ Y				
23a or ist be r	Funeral Director	10e. Street and Number 121 Conestoga	Pond			10f. Zip Code 212	10g. Citizen of Wha					
items ner mu		11. Marital Status	12 Was Decedent 8	ver in U.S		Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			-	United S	rican Indian,	
ral", or Exami	Completed by	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☑ Divorced	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	9 1	,	Black, Wh		White				
"natu ledical	plet	15. Decedent (Specify only highes			(Give k	Decedent's Usual Occupation (Give kind of work done during most of working				Kind of Business	Industry	
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27 is m traum		19a. Informant's Name/Relationshi Joseph J. Wiegan Joseph J. Wieg	o (Type, Print)		1		and Number or Re			or Town, State, Zip	Code)	
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Important in any ir once.	. 10	21. Signature of Funeral Service Lic	ensee	4015	535 22.		son Failly F				1 1 01000	
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To the Funeral D		29a. Certifier Certifying P	hvsician: To the best of r	ny knowle	dge, death or	cured at the time	date and place				ed	
npletec	Medical										auca(e) and manner eta	
CO		29b. Signature and title of certifier	2)			29c. License			29d. Da	ate signed (Month,	Day, Year)	
- 1	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)										10	
	I	DAVID DUNN -	615 W. MACH	HATL	ROAD	- BEL	AIR, MD.	21014				
State		31. Date filed (Month, Day, Year)	32 Registrar									

Director 28a-f show "natural", or items 23a or 28a-f shor edical Examiner must be notified at death with the Maryland 72 hours after Medical permit. Page 1 and 2 should be filed within 72 t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any injury or other traumatic event, the Markin once. Maryland 2121 2010 Baltimore,

P.O. Box 68760 CORBET Records, PRISCILLA of Vital

State Registrar DHMH 17 Rev 7/2009

For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year PRISCILLA ANNE CORBETT MAY 2010 6:35 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BALTIMORE STELLA MARIS HOSPICE TIMONIUM Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Yea 1 ☐ M 2 😿 F Months Days Hours Min Country) Maryland 213-40-0377 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 920 Whispering Ridge Lane 21015 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 No If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Tress Weller Sr. Margaret Cleo Kaine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Carroll Corbett / Husband 920 Whispering Ridge Lane, Bel Air, MD 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Hilltop Service Corp | 5-7-10 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fineral Service 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) PERITONEAL CANCER Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leaving to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours alrefeath.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burnal-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 **X** No 2 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 **X** No Other ျှ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, it my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5/10 13725 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TARIQ MAHMOOD, MD -2300 DULANEY VALLEY RD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

TIMONIUM, MD 21093

22. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year RUMPTON 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE HOSPITAL SALTI MORE If Under 1 Year | If Under 8. Date of Birth (Month, Day, Year) 11/11/1946 Birthplace (State or Foreign Country) MD 7. Age (In yrs. last birthday) 63 yrs 212-46-9790 Months Days Hours Min TX M 2 □ F Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD Anne Arundel Brooklyn 10e. Street and Number 215 Audrey Avenue 10f. Zip Code 10g. Citizen of What Country? 21225 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 XXo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 □ Never Married 2 □ Married 1 □Yes 2 No Specify. If Yes, Give Year or Dates white Specify: 3 ☐ Widowed 4 ☐ Divorced 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Carpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dorothea Fontz Unknown ^{19a,} Informant's Name/Relationship (Type.Print) Stephanie M. Fulk / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2103 Holly Neck Road, Essex MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) Ardent Crematory 20a. Method of Disposition Date 20c. Location - City or Town. State 1 ☐ Burial 2 2 Cremation 3 ☐ Removal from State 5/11/2010 Hanover Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service LicenseeVictor P. Doda, Jr 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 🗌 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 1 ☐Yes 2 ☐No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit P.O. Box 68760, Physician/Medical signed by the a Division of Vital Records, ş s been si should I Completed After this certificate has page 2 To the Hospital or Attending Physician: funeral director, Be Certification: To within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Physician

Examiner

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

altimore, Maryland 21215-0036

?7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar is unt be notified at

Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, In Magnes.

Physician

Examiner

/Medical

Funeral Director

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Completed

Be

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/Medical

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) 29b. Signature and title of certifier

29c. License number

STREET

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HUANG 31. Date filed (Month, Day, Year) State

29a. Certifier

Medical

SOUTH MAY 0 2010

and manner stated

Registrar's Signat

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARY LOUISE DOBBS MAONTH 20^VPN 3:00 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death STELLA MARIS HOSPICE TIMONIUM BALTIMORE 5. Social Security Number Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 🖫 F Months Days Hours Min (Month, Day, Year) MARCH 18,1922 88 Director MD 213-12-0575 Usual Residence of Deceden shov ral", or items 23a or 28a-f shor Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🙀 No MD BALTIMORE TIMONIUM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 2300 DULANEY VALLEY RD APT C203 21093 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🕅 No permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural any injury or other transmank." Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates WHITE Specify: 3 X Widowed 4 Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 MEAT DEPARTMENT GROCERY STORE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JAMES TYLER MEEK MARIE CATHERINE KAUFMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOANN SHARP-DAUGHTER 1019 SAXON HILL DRIVE COCKEYSVILLE, MD 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State GARDENS OF FAITH 5/8/10 BALTIMORE, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC 6415 BELAIR RD BALTIMORE, MD 21206 23a. Part 1 Inter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) DEMENTIA Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy jo in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Pregnant at time of death Day Year After this certificate has been signed by the funeral director, page 2 should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X N death? the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Tes 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6X Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No after death Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🕱 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the Within 2 only one 29b. Signature and tit 29d. Date signed Month. Day. Year) berson who completed cause of death (Item 23a) (Type, Print) 30. Name and a JACKTE JONES. CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Mortth, Day, Year)

gistrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Muella 10114 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Northwest Hospital Randallstown Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 🛠 🗆 F Months Hours Min Director 81 220-24-2485 05 08 28 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, "h. M. M. Cale France in the prunting a 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1√2Yes 2□No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2725 Walbrook Ave 21216 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2√□ No Specify: þ Specify: Black 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Union Memorial Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Dietary Aide Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ ပ Benjamin Chester Emma Hawkins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Monet Chester Daughter 4314 Sheldon Ave, Baltimore, Md 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Nation | 2 □ Cremation | 3 □ Removal from State 4 Donation 5 ☐ Other (Specify) 5/10/2010 Arbutus, Arbutus Memorial of Funeral Service Lensee 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. rcaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician tai luvc disease or condition resulting in death) /Medical Due to (r as a consequence Examiner Sequentially list conditions day, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine V204 burial-tra Hospital or Attending Physiclan: The law requires that the death certificate be exect Due to onas a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ned by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 certificate has been significate, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 2 🗆 No 2 No 1 ☐ Yes 1 □ Yes Be (director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1∐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier completely (Check only one) within 2 To the I 29b. Signature and title of carfiller 29c. License number 29d. Date signed (Month, Day, Year) 2010

Registrar

State

Name and address of person

31. Date filed (Month, Day, Year)

Harlun

who completed cause of death (Item 23a) (Type, Print) Old

32 Registrar's Signature

Ct.

5401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4323 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May 3, 6:45 P M Carl Edward Dumps 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center for Hospice Care Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 61 Days Hours Apr 12 Year) 1949 212-58-4379 Director Yrs Maryland Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department or Health and Mental Hygiene. Important: If item 27 is marked other than "--- any injury or other than "----10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Baltimore Parkville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8800 Walther Blvd. unit 4109 21234 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 No If Yes, Give 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Clerk Giant Foods Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ρ Carl Louis Dumps Jolanda Lendle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jolanda Sitter /Mother 1107 Fox Den Road Bel Air, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May 05 1 Burial 2 Cremation 3 Removal from State Chesapeake Crematory Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives M01443 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Difficile Colitis MIDIM weeks Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence or, the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Dav 2 No ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 □ Probably 4 □ Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform After this certificate Yes 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospita 2 No Other: မ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) NOS (27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 💫 Natural 5 Pending Accident Investigation 1 Tes 2 No 6 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b, Signature a d title of certifie

DHMH 17 Rev 7/2009

State

Registrar

AMON

31. Date filed (Month, Day, Year)

6

32. Registraf's Signature

MOZERO

M

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HARVES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 1 0

			for State Registrar	State of Ma	iryiand		artment of F tificate of L		Mental Hy	giene Reg. N	201	0	14324
	Physicia	an/	1. Decedent's Name (First, Middle, Lateral Bertha C.	,					2. Date of De	ath		ar	3. Time of Death
j	Medi Examir		4a. Facility Name (if not institution, give				4b. City, Town, or	Location of Dea	May 1,		c. County of D		3:45 P M
	j.		8803 Lew Wallace	Road			*	rbana			Frede		
	Funeral Director		5. Social Security Number 6. S 238–28–7279 1 Usual Residence of Decedent	ex	(In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th Y, ^Y 192	9. 21 No	Birthpla Couptry rth	ce (State or Foreign Carolina
	and show dat	ğ	10a. State 10b. County		10c. City,	, Town or Loc	ation					100	d. Inside City Limits
	Mary 28a-f otifie	Director	Maryland Frederi	c k			Urbana						1 ☐ Yes 2 🔯 No
	ith the 23a or at be r		10e. Street and Number 8803 Lew Wallac	n Pood			10f. Zip Code	70/		-	itizen of What		
	eath w	Funeral	11. Marital Status	12. Was Decedent Ev	er in U.S.	. 13. W	B 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1					ed States Race - American Indian,	
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy follury or other traumatic event, the Medical Examiner must be notified at once.	Completed by F	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced		1 L Yes 2 X No If Yes, Give			n, Mexican, Puer Specify:	to Rican, etc.)		Black, W Specify:Wh	/hite, etc	
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Ma	12 sho alth an 27 is r trau	Y	19a. Informant's Name/Relationship (T) Patricia K. Dowge		ter		Armetale					•	_{de)} ginia 22039
Baltimore,	of Hear of Hear fitem rothe		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐		20b. Pla	ace of Dispos	ition (Name of		e ^{Date} ,		ocation - City	_	
ij	Page tment tant: I		4 Donation 5 Other (Specif	Hemoval from State	Arī Nat	ingtor iofial	atory or other place Cemetery	20	10	Ar1	ington	, V:	irginia
Bal	Depar- Impor- any in	. (9	21. Signature of Funeral Service Licens	hout	MO14	98 R	Sckvitte;	Marylai	nd 26850	Pum Mont	phrey	Fune	eral Home/
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928		Med	IF FEMALE:										
P.O. Box 68760	ath certific attending p for use as		23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live Birth 2	☐ Fetal of	death 3 🗌	Ectopic pregnancy	/			23d. Date of		
М	he dea y the a iched t	hysic	1 🗌 Yes 2 🖾 No 9 🔲 Unknown	4 Pregnant at t 9 Unknown	ime of dea	atn 5 🗆	Other (specify)				WOTET	Da	ay Year
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<u> </u>	nysicia nis cer direct	To Be	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatien	t 2 🗆 Ei	R/Outpatient	Other	-	dome 5 🔀 Resid	ence 6	☐ Other (Sp	ecify)	
Division of Vital Records,	or Attending Physician; The law requires that the death certif after death. after death. after death. after death. after death. after death. after death certificate has been signed by the attending in by the funeral director, page 2 should be detached for use a fine by the funeral director.		27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day,		8b. Time of injury	28c. Injury work? M 1 🗆	at ∕es 2 □ No	28d. Describe h	ow injury	occurred /		
28d. Describe how injury occurred work? 1											Rural Ro	oute Number,	
2	ital or urs aftu ral Dir lled in			building, etc. (City or Tow				10
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by th	Medical	(Check 2 \(\sum \) Medical Exami	ician: To the best of my ner: On the basis of exam Practioner: To the be	mination a	and/or investic	ation, in my opinior	. death occurred	at the time date ar	nd place	and due to the	001100	(s) and manner stated.
	To th Comp		29b. Signature and title of certifier	/ /	K		29c. License		1		te signed (Mor		
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			30. Name and address of person who c Gail Griffin, M.				Street,	Mt. Airs	7. Marv1:	and	21771		
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	Registra	_		10		A has	a dad						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4325 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 29, Day 2010 Year Dorothy L. de Court 9:30 Ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death 8101 Hampden Lane Montgomery Bethesda **Funeral** . Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛣 F Months Days Hours 243-26-8122 Director September II, 1925 North Carolina 84 Usual Residence of Decedent fshov ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 72 hours after death with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Montgomery Bethesda 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8101 Hampden Lane 20814 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? 9 Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 Yes Specify: White 1 ☐ Yes 2X No Specify: If Yes, Give 3 X Widowed 4 □ Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 In and Mental Hygiene.
7 is marked other than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate Agent Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles S. Loving Gertrude A. Daniel other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sl ment of Health a tant: If item 27 is 5900 Ipswich Road, Bethesda, Maryland 20814 Amelia de Court / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) injury or permit. Page Department of Important: If 4 Donation 5 Other (Specify) Montgomery Crematorium, Inc. May 3, 2010 Bethesda, Maryland 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814—3501 Athor for M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ∜nysician/ disease or condition resulting in death) Coronary Artery Disease Medical Due to (or as a consequence of) Examiner Ischemic Cardiomyopathy Sequentially list conditions Examine Dunito (or as a consecuence on cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year be detached signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical director. Be 26. Place of Death (Check only one) examiner? 2 🗓 No Certificate; To 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at after death. Director: After 28d. Describe how injury occurred 1 🕅 Natural 5 Pending injury work?
1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, within 24 hours a

To the Funeral D Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

2

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person v

<u>Alpana Goswami</u>

31. Date filed (Month, Day, Year)

32. Registrar's Signature

AAY 0 7 2010

Leave f. Sarke

o completed cause of death (Item 23a) (Type, Print)

M.D.

ORIGINAL

D27660

11125 Rockville Pike #110, Rockville, Maryland 20852

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 04-29-2010 0850 P Roger Dale Erwin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Forest Hill Health & Rehab, Forest Hill . Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 💢 M 2 🗆 F 62 Months Hours Sept. 22, 1947 Missouri 527-72-5692 Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Bel Air 1 ☐ Yes 2X No Harford Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 "natural", or items 23a or Funeral 21014 1 Glenwood Place U.S.A. 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11 Marital Status Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married by Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify: If Yes. Give Specify: 3 Widowed 4 Divorced Completed In Mental Hygiene.

S marked other than "natura"

matic event, the Medical E Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) I year retail store vice president Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked oth any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Erwin Evelyn Catherine Warnaka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenwood Place Bel Air, MD 21014 Wanda Ruth Erwin / Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Valley of the Sun Cem. 05-05-2010 Chandler, AZ 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Si natur of Funeral Service Licenses Inc. 610 W. MacPhail Rd. Bel Air, MD 21014 233 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, metastutu disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ 9 ☐ Unknown a 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform 1 Yes 2 No 1 ☐ Yes 2 l Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗓 No Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: iniury Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

DHMH 17 Rev 7/2009

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Régistrar's Signature

29c. License number

03523

29d. Date signed (Month, Day, Year)

30,2014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day Month Year Physician/ 35P Mav Charles Wesley Ford, Sr Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Perry Hall Balto. 9601 Amberleigh Lane Apt.R 8. Date of Birth (Month, Day, June 7. If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In yrs. last birthday) 5. Social Security Number Funeral Days 1**X**□ M 2 □ F Months Hours Yrs Pennsylvania **Director** 204-20-8252 Usual Residence of Decedent 10d. Inside City Limits show 10c. City, Town or Location 10a. State 10b. County within 72 hours after death with the Maryland the Medical Examiner must be notified at Director 1 Yes 2 No 28a-f Perry Hall Balto. 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 0 Funeral items 23a 21128 9601 Amberleigh Lane Apt.R Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 10 / 5 . 1 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ŏ þ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 1945–1965 'natural", 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) U.S.D.A. Food Inspector Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important; If item 27 is marked ott any injury or other traumatic event ၉ Adeline Bensinger Charles Ford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Perry Hall, Md. Apt. R 9601 Amberleigh Lane Anna M. Ford Spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-8-2010 Balto. Md. Bayview Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham. Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Interval Between Onset and Death Immediate Cause (Final POHA Physician/ disease or condition Medical resulting in death) Due to (or as a contequence of) Examiner CETASTATIC Sequentially list conditions, Examine Due to for as onsequence of if any, leading to immedicause. Enter Underlying and I-transit Cause (Disease or linjury that initiated events law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last the attending physician a hed for use as the burlal-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death g 🗌 Unknown cate nas been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has I performed 2 🗹 No To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director, page Yes 2 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes ျ 28b. Time of 28c. Injury at 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 29b. Signature and title of certifier D55356

Registrar
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State

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WO

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Flowers Physician/ heron 2:50 AM Month 200 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Loch Kaven Community Living 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours Min N'Carolina Director al Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits Director 1 Ces 2 No more Street and Number 10g. Citizen of What Country? Funeral lover Cou .5 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Specify: 3 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NQT use retired) I Hygiene. other than " College (1-4 or 5+) and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) မ permit. Page 1 and 2 should to Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relation Fig Tree Pho Doug L 95. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) love. 20b. Place of Disposition (Name of 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or 21. Signature of Euneral Ser any 11015 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ letastat LC disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) The law requires that the death certificate be executed sician and burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: dspice 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 5 Pending within 24 hours after death.

To the Funeral Director: At completed filled in by the fu Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within To the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) icho to 04136 2 2010 May 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3900 Loch Ro Severine E. Wicks M. M. Bettimore Boulevard Kaven 31. Date filed (Month, Day, Year) Registrar's Signat State Registrar

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Baltimore, Maryland 21215-0036

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Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Michael S. Garczynski 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 9120 Kilbride Rd. Nottingham Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 XM 2 F Months Year Yrs. **Director** 213-03-6278 89 Marvland Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Balto. Md. Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9120 Kilbride Rd 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, med Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1944-1946 Year or Dates: 944-1946 1 ☐ Yes 2 X No Specify. White 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary & Treasurer B&O Railroad permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be file h and Mental h 7 is marked ot 2 Vincent Garczynski Frances Malinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR. Bernadine Grzybowski 14 Moray Ct. Nottingham, Md. 21236 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart of Jesus 5-7-2010 Dundalk, Md. 21. Signature of Funeral Service License 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Diratio Physician/ nenmonia disease or condition resulting in death) Medical Due to (or as a onsequence of): Examiner alzheimer 15eas-e Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and tran Due to (or as a consequence of): resulting in death) Last physician a sthe burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death n signed by the a Yes 2 No 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by arkinson's 1 Yes 2 No 3 Probably 4 Unknown has been signed to should to be a should to be should to be a should to be a should to be a should to be a shou 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate | 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 1 No ည 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hopkins Baynen Corcle, Balkmone MD

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31. Date filed (Mor

egistrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Gorsuch Antoinette Mas 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore osedale Samare 05 If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Jan. 18, Birthplace (State or Foreign Country) Age (vrs. last birthday) **Funeral** 212-44=2034 1 □ M 2 😡 F MD Yrs 66 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shoi injury or other traumatic event, The Madical Experiment must be profitted at Essex Baltimore MD 1 ☐ Yes 🏖 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21221 1732 Glen Curtis Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 3€ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Maryland 21215-0036 þ SpecifyWhite 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Resteraunt Waitress permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If frem 27 is marked other the any injury or other transment. 11th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thelma E. Dashields Louis V. Mikles 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1732 Glen Curtis Road Baltimore MD 19a. Informant's Name/Relationship (Type. Print) Robert GorsuchIII /son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holly Hill Cemetery 5/8/10 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility 22. Name and Address of Facility 300 Connelly Funeral Mace Aye Balto MD Home of Essex 21221 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner prative Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequency of): Examine certificate be executed ritonitis and burial-Due to (or as a consequence of) Box 68760, physician Physician/Medical the as attending p If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a □Yes 2 No P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate ocamdia 1 ☐ Yes 2 K No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician; 25. W s ase referred to medical examiner? director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) r⊈ Yes 2 No 1 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

The Funeral Director: A pletely filled in by the death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical npletely (Check only one) and nanner stated within 2 29d. Date signed (Month, Day, Year) 29b. Signature and tiple 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Square Drive Baltimore

State Registrar

Stephen S

onth, Day,

Year)

31. Date filed (N

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ORIGINAL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 49 PM Yea **Physician** Phyllis Max Ann Green 2010 /Medical 4a. Facjilty Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner altimore Medical Center OWSON Himore 8. Date of Birth 10/31/1949 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔯 F Months Days Hours Min Maryland 60 Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinations to redified 1 XYes 2 No Director N/A Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 481 Watty Ct. 21201 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates: <u>م</u> Specify: Black 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ementary/Secondary (0-12) College (1-4or 5+) N/A 8th Grade N/A17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick ပ Brown Ida Mae unk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Diane Johnson (Daughter) Item 27 other t 2714 E. Madison St., Baltimore, MD 21205 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department o Important: If any injury or once. = 5 1 ☑XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carmel Cem. 05/13/10 Baltimore, MD ²Joseph^{dd}H^{s of} Brown Jr. Funeral Home 2140 N. Fulton Ave. Baltimore MD 21. Signature of Funeral Service Licensee N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enger the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final sepsis Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live birth 2 \square Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Ye ar 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 2 No 3 Probably 4 Unknown been si should I 1 ☐ Yes Completed certificate has b 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

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Day, Year)

Cynthy

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Soriano MO

DOD 513 47

6701 N. Charles St Baltimore MO 21204

for State Registrar

29a. Certifier

Director

Funeral

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Completed

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Examine

Registrar					Ce	rtifica	ate of l	Death		Reg	. No. 2	010	1	33:
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. Facility Name (ii	not institution,	give street and nur	nber)			4b. C	•	r Location of Dea			4c. Cou	inty of Death		
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215–28–0	691	6. Sex 1 ☐ M 2 🔀 F	7. Age	78 78	st birthday) Yrs.	Month		Hours Min		Month, Day, Ye 03/22/19		Balti	place (State ptry) I more	or Foreigi
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Maryland	Harford	County		Fore	st Hill								1 🗆 Ye	s 2 🔀 N
e. Street and Nu 1310 Sharc		Road				10f. 21	Zip Code 050	•		Ůn	g. Citizen	of What Cour States	ntry?	
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Father's Name			<u>, </u>					18. Mother's Na Mary Bohl	me (/	First, Middle, Mai 1	den Surn	ame)		
Pa. Informant's N					19b. Mail 1310	ling Addr	ess (Street n Acre	and Number or Ri S Road, Fo	ural F	Route Number, Ci St Hill, M	ty or Tow bryla	n, State Zip (nd 21050	Code)	
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transif

Medical Certificate: To Be Completed by Physician/Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5 かろフマグラ

BEL AIR, MD.

21014

State Registrar

615 WEST MACPHAIL ROAD DAVID DUNN 31. Date filed (Month, Day, Year) **MAY 0 7 2010**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last)
John I. 2. Date of Death Gilfillan. Jr. Physician/ Month 4/29 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Hospice Towson 8. Date of Birth (Month, Day, Yea 5/14/30 5. Social Security Number Funeral 6 Sex 7. Age (In yrs. last birthday) Min. Months 187-22-6458 txxx M 2 □ F 79 Hours Director Usual Residence of Decedent show 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho dical Examiner must be notified at 10c, City, Town or Location Director York New Freedom 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 32 Still Pond Drive 17349 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian Armed Forces? Army Completed by Black, White, etc. 2 🗆 No 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 Ko Specify: If Yes, Give Korea Specify 3 XXWidowed 4 □ Divorced Year or Dates id Mental Hygiene. marked other than "natu matic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Social Security Admin. Federal Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ္ 1 and 2 should be f f Health and Menta item 27 is marked other traumatic ev John Irwin Gilfillan, Sr. Hannah Rieck 19a. Informant's Name/Relationship (Type, Print)

Johanna Tittel / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 623 Piccadilly Rd, Towson MD 21204 other Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I Important: If it any injury or of once. ᇴ cemetery, crematory or other place)
West Alexander Cemetery 5/6/2010 1 Burial 2 Cremation 3XXRemoval from State West Alexander, PA 4 Donation 5 Other (Specify) Jr. Name and Address of Facility
Charles L. Stevens Funeral Home, Inc.
1501 E. Fort Ave, BAltimore MD 21230 21. Signature of Funeral Service Licensee Victor P. Doda. 1100 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death signed by the at d be detached for 9 Unknown 9 Unknown To the Hospital or Attending Physician: The law requires that the orthin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24a. Was an page 2 s autopsy performed' Yes 2 N **Division of Vital** funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at within 24 hours after death.

To the Funeral Director: After to completed filled in by the funeral Natural 5 Pending Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \square Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 4 Nursing Home 5 Residence 6 A Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Charle ST TONSON MO

3. Time of Death

Baltimore

USA

9. Birthplace (State or Foreign

10d. Inside City Limits

white

Approximate Interval Between Onset and Death

Day

Year

months

XX Yes 2 No

8:08amм

31. Date fil

6701

and address of person who completed cause of death (Item 23a) (Type, Print)

MUES

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	•	artment of Health and N tificate of Death		ene , No.2010	14334
	Physicia		1. Decedent's Name (First, Middle, Last) Rosamaria N. Ilardo	Howard		2. Date of Death Month May 4, 201	Day Year	3. Time of Death 2:47P
	Medic Examin		4a. Facility Name (if not institution, give street and Franklin Square	number)	4b. City, Town, or Location of Death Rosedale	142	4c. County of Death Balto	
	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 🗵	7. Age (In yrs. last birthday) 47 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye November	ear) Coun	place (State or Foreign htry) 1aryland
	aryland ta-f show ffied at	Funeral Director	Usual Residence of Decedent 10a. State 10b. County Md • Balto •	10c. City, Town or Loc	Perry Hall			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the M or 28	i Dir	10e. Street and Number		10f. Zip Code	100	g. Citizen of What Cour	ntry?
	h with	nera	9810 Forge Park Rd.		21128		USA	
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married 1 Street Married 3 Widowed 4 Divorced Fyear	Yes 2 No , Give 1 or Dates.	Vas Decedent of Hispanic Origin? (Spot Yes, specify Cuban, Mexican, Puerto Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Wh	
1215-	ithin 72 hor ene. • than "nat he Medica	Completed	15. Decedent's Education (Specify only highest grade comple Elementary/Seconday (0-12) 1 Colle Master	eted) (Give I ge (1-4 or 5+) (life. Do	lent's Usual Occupation kind of work done during most of work O NOT use retired) .nistrator	ing	Sb. Kind of Business In Catonsvill College CO	
Baltimore, Maryland 21215-0036	i be filed w fental Hygi rked other tic event, t	To Be	17. Father's Name (First, Middle, Last) Joseph Ilardo		18. Mother's Nam	e (First, Middle, Mai	iden Surname)	
Aary	should and M is ma rauma		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or Run			
ore, 1	ge 1 and 2 it of Health If item 27 or other t		William A. Howard 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal	20b. Place of Dispo cemetery, cren	natory or other place)	Date 20	c. Location - City or To	
3altim	permit. Pag Departmen Important any injury once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Gardens o	. Name and Address of Facility Sch	imunek Fu		
	TU = 60		23a. Part 1. Enter the disease, or complications to	that dused the death. Do not enter	9705 Belair Rd. er the mode of dying, such as cardiac			Approximate
_,	Physician/ Medical		shock, or he in failure. List only one cause of Immediate Cause (Final disease or condition resulting in death)	ordino +	rrost	^		Interval Between Onset and Gooth
	Examiner	ner	Sequentially list conditions, if any, leading to immediate Du	e to (or as a consequence of):	ic Breast (bincen		2 by
	ate be executed hysician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events c.	e to (or as a consequence of):				- (
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Box 687	the Hospital or Attending Physician: The law requires that the death certificate be executed that 4 hours and early careful and the Functural affect death. The functural affect death. The functural affect this certificate has been signed by the attending physician and the functor, page 2 should be detached for use as the burial-transity and the functural director, page 2 should be detached for use as the burial-transity.	Physician/Me	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of deliv Month	ery Day Year
Division of Vital Records, P.O.	uires that the signed by and be detac	by	Part II. Other significant conditions contributing	to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	cco use contribute to the	he cause of death?
Record	ysician: The law require is certificate has been si director, page 2 should I	Completed	1			24a. Was an autopsy performed 1 Yes 24	prior to co	psy findings available ompletion of cause of
<u>ta</u>	iician: The certificate rector, pag	Be	25. Was case referred to medical examiner? Hospital:		26. Place of Death (Chec	k only one)		
of V	g Phys er this reral dir	te: To	27. Manner of Death 28a. I	1 Inpatient 2 ER/Outpatier Date of injury Month, Day, Year) 28b. Time of injury	nt 3 □ DOA 4 □ Nursing He	ome 5 Residence 28d. Describe how	ce 6 Other (Specif) injury occurred	<u>/)</u>
ion	l or Attending after death. Director: After I in by the funer	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	Place of Injury - At home, farm, stre	M 1 ☐ Yes 2 ☐ No	ORE Leasting (Otton		I Davida Musebara
Divis	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral	al Cer	4 - Homicide determined	ouilding, etc. (Specify)		City or Town, S	,	·
	To the Hospital within 24 hours a To the Funeral C completed filled	Medical	(Check 2 Medical Examiner: On th	e basis of examination and/or invest	occured at the time, date and place, ar tigation, in my opinion, death occurred a death occurred at the time, date and pla	it the time, date and p	place, and due to the ca	use(s) and manner stated.
	To # within		29b. Signature and title of certifier 1 Man Wh		29c. License number 36814	290	d. Date signed (Month,	Day, Year)
_			30. Name and address of person who completed	er Dr. S		wson	,mD	21204
	Stat Registra		31. Date filed (Month, Day, Year) MAY 0 7 2010	32 Registrar's Signatur	all			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Year Mav 2010:45 Α Christina Lynn Hess Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Gilchrist 9. Birthplace (State or Foreign Country) Maryland 6. Sex 7 Age (In vrs. last birthday) If Under If Under 24 Hrs. 8. Date of Birth 5. Social Security Number Funeral Months Days Hours Min. July 17 1 □ M 2 및 F Yrs Director 214-50-5343 61 Usual Residence of Deceden 10b. County items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland traumatic event, the Medical Examiner must be notified at Director 1

Yes 2 □ No Md. **Baltimore** 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 3711 Raspe Avenue 21206 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. P 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify. Specify "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Patient Care Associate Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o and Mental His marked o ပ Elizabeth Hooper George Rabenau 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21206 Harry Hess Spouse 3711 Raspe Avenue Balto. Md. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 5-6-2010 4 Donation 5 Other (Specify) Most Holy Redeemer Balto. Md. 21. gnature o Fox 22 Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition month Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Duvito (or as a consequence oi): the Hospital or Attending Physician; The law requires that the death certificate be executed the burial-transit attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) page 2 should be detached the Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed Yes 2 2 No 1 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Tes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.

Funeral Director: After this 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work?
1 Yes 28d. Describe how injury occurred Natural 5 Pending 2 🗆 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 296 License numbe 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

ORIGINAL

TOWSON ME

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1AMMES

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			for State of M	aryland / Depa <i>Cer</i>	artment of He tificate of De			ene 99. No. 201	0 4336
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Howard A. Huff Jr	•			2. Date of Death	Day 1	3. Time of Death
	Examin		4a. Facility Name (if not institution, give street and number)	ocation of Death	T	4c. County of	Death L		
	Funeral Director			ge (In yrs. last birthday) 62 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth June 10	Year) 9 4 7	Birthplace (State or Foreign Country)
	aryland a-f show fied at	Director	Usual Residence of Decedent	10c. City, Town or Loc		Dr Grad	ee		10d. Inside City Limits 1 ☐ Yes 2X No
	with the Ma 23a or 28a ust be notif	Funeral Dire	1 10e. Street and Number 205 R Secretariat Dr	ive	10f. Zip Code 210	78	1	0g. Citizen of Wha	t Country?
36	after death	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces? 1 X Yes 2 If Yes, Give	No I	Was Decedent of Hisp If Yes, specify Cuban,	Mexican, Puerto	ecify Yes or No- Rican, etc.)	Black, V	American Indian, Vhite, etc. White
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 1 2 th	5+) (Give life. Do	dent's Usual Occupati kind of work done dui O NOT use retired)	ion ring most of worki	ing	l 16b. Kind of Busin Wagons	
land ?	i be filed w fental Hyg rked othe tic event,	To Be	17. Father's Name (First, Middle, Last) Howard A. Huff Sr.	nai			e (First, Middle, M	laiden Surname)	
Mary	d 2 should alth and M 1 27 is ma er trauma'		19a. Informant's Name/Relationship (Type, Print) Sharon Huff /wife		ng Address (Street and			•	e, Zip Code) De Grace MD
Baltimore,	Page 1 an nent of He ant: If item any or othe	-	20a. Method of Disposition 1 IXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo	osition (Name of matory or other place) ill ceme	te r y 5/	Date 75/10	20c. Location - Cit Baltim	•
Balt	permit. Departr Imports any inji		21. Signature of Funeral Service Licensee	1		y Funer	al Hom	e of Es	alto. MD sex 21221
ı	2hysician/		23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each lin Immediate Cause (Final disease or condition	the death. Do not entered TAGE - DEMI		such as cardiac o	or respiratory arre	st,	Approximate Interval Between Original Parti
	Medical Examiner	Je.	Sequentially list conditions, b.	a consequence of):					
_	cate be executed physician and s the burial-transit	cal Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events c.	a consequence of):					
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transic completed filled in by the funeral director, page 2 should be detached for use as the burial-transic.	Physician/Medical		2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date o	f delivery Day Year
s, P.O.	ires that the signed by	ρχ	Part II. Other significant conditions contributing to death	out not resulting in the u	underlying cause give	n in Part I.			te to the cause of death?
Record	The law requate has been bage 2 shou	Completed					24a. Was ar autops perforr 1 \sum Yes 2	y prio ned2 dea	e autopsy findings available r to completion of cause of th?
lta (sician; certifica irector, p	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	tient 2 🗆 ER/Outpatier	Other	ce of Death (Check		nce 6 Other (S	Descrited
n of \	iding Phy th. After this funeral d	cate: To	27. Manner of Death 1 Natural 5 Pending (Month, Death (Month), De	ury 28b. Time of	f 28c. Injury a work?		28d. Describe ho		респу)
Divisio	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director Atter this certificate has completed filled in by the funeral director, page 2	Certificate:	3 Suicide 6 Could not be 28e. Place of In	jury - At home, farm, stre c. <i>(Specify)</i>	reet, factory, office		28f. Location (Str City or Town		r Rural Route Number,
	To the Hospital within 24 hours a To the Funeral C completed filled	Medical	29a. Certifier 1	examination and/or invest	stigation, in my opinion death occurred at the t	, death occurred a time, date and plac	t the time, date and be, and due to the	d place, and due to cause(s) and manne	the cause(s) and manner stated. er as stated.
	o o o		29b. Signature and title of certifier	de our	29c. License r		2	9d. Date signed (M	fonth, Day, Year)
			30. Name and address of person who completed cause of a CANLINA RUSTONIO, M.D.	Jeath (Item 23a) (Type, F			EM, PERRY	POINT, M	0 11901
1	Sta		31. Date filed (Month, Day, Year) 32. Registr	rar's Signature	ald		,	7	

DHMH 17 Rev 7/2009

NAME KNOWN TO PHYSICIAN: HUFF, HOWBRD AUSTIN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗋 For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 7, 2018 John V. Hulser 6:15 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Tate Hospice House Linthicum Anne Arundel Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 - F Days Min. Janonth, 30, Year 927 Hours 83 New York **Director** 046-22-7978 Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Glen Burnie 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7975 Crain Hwy., S, Apt. 310 21061 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 🔯 No If Yes, Give 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 🗌 Widowed 4 🙀 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) College Professor Education æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ John Hulser Mae Wolfe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Faye Burns / Friend 7975 Crain Hwy., S, Apt. 310, Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State May 8 2010 Metro Crematory, Inc. 4 ☐ Donation 5 ☐ Other (Specify) Catonsville, Maryland 21. Signal ye of Noveral Se Rirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 21061 3 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset Death Immediate Cause (Final h sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Physician/Medical Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a cons the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequency IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 2 🗌 No been signed by the should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2: autopsy performed? 1 ☐ Yes 2 🖾 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 🔀 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🕱 Other (Specify) Hospice 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

State Registrar 29a. Certifier

29b. Signature and title of certifier

Sukhpal I.

31. Date filed (Month, Day, Year)

WYM

30. Name and address of person who completed cause of the hitem 34 (Type, Print)

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

32. Registrar's signature

1 😾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 🔾 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1600 Crain Hwy., S, Glen Burnie, Maryland 21061

29d. Date signed (Month, Day, Year)

May 7, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 05 04^{Day} 2010 1:35 AMM Clara Virginia Hall Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Oak Crest Care Center Parkville If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth Birthplace (State or Foreign Country)
 North Carolina 7. Age (In yrs. last birthday) **Funeral** Hours Min. 1 🗆 M 2 💢 F 07/24/1923 Director 244-20-2705 86 Usual Residence of Decedent Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Examiner must be notified at Director or 28a-1 1 Yes 2 No Parkville MD Baltimore 10f. Zip Code 10e, Street and Numbe 10g. Citizen of What Country? 23a Funeral 21234 U.S.A. 8820 Walther Blvd. - Apt. 2515 or items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, Black, White, etc. þ 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White and Mental Hygiene. is marked other than "natural", 3 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Lever Brothers Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Girtha Mae Kirman William Riley Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 3205 Tally-Ho Place - Fallston, Maryland Michael D. Watkins (friend) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Highview Memorial Gdr. 05/07/2010 | Fallston, Maryland 4 Donation 5 Other (Specify) ign tule of Funeral Service Ocensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final atherosclerotic Cardiovaxular Disense Ph, sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of, Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical certificate be IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PVD, Vaxular Dementia No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 1 Tyes cate has been sig page 2 should b Completed 24a. Was an 24b. Were autopsy findings available autopsy performed? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director, After this certificate I completed filled in by the funeral director, pagr 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural (Month, Day, Year) 5 Pending work' 1 ☐ Yes 2 ☐ No Investigation Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 104 2010 CLUP MSN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Michealle G. Harrison (KNP MSW 9800) Walther Blvd, Packville, MD 21234

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 8:54 PM Robert Himes, Jr. James May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Aberdeen 384 Center Deen Ave. 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland Funeral 7. Age (In yrs. last birthday) 1 X M 2 🗆 F Hours 8/377946 63 Director 219-42-9248 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Aberdeen 1 Yes 2 ☐ No Maryland Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21001 UŠA Funeral 384 Center Deen Ave filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. 1 Never Married 2 M Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify. SpecifyWhite "natural", 3 Widowed 4 Divorced Completed event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) iould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) District Court Bailiff State Government n 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Gladys Lawrence James Robert Himes, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 384 Center Deen Ave, Aberdeen, MD 21001 Karin Himes / wife Baltimore, 20a. Method of Disposition
1 ☐ Burial 2

Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State West Chester, Date cemetery, crematory or other place) 5/7/2010 4 ☐ Donation 5 ☐ Other (Specify) R.A. Ferris & Co. Pennsylvania 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. 333 S. Parke St. Aberdeen, MD 21001 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Due to (or as a const uence of): Pulmonary disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any local gradient cause. Enter Underlying Examir The law requires that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Pregnant at time of death Month Day Year Yes 2 No the detached 9 Unknown 9 Unknown Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autops\ eral Director: After this certificate I filled in by the funeral director, page 1 Yes 2 No ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner' Other: 4 Nursing Home 1 🗌 Yes မ 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending work? 1 ☐ Yes 2 ☐ No after death. Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State within 24 hours a To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check 3 Certifying Nurse Pr ctioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certific 29d. Date signed (Month. Dav. Year) D0063981 M.D. ted cause of death (Item 23a) (Type, Print) 30. Name and address of person who com

State Registrar Benjamin Lee

ed (Month, Day, Year)

669 Revolution 5

Havre de Grace, MD 21078

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Margarete Loibl Hinch May 4. 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Harford Memorial Hospital Havre de Grace Harford 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 M 200F 78 Yrs. Director May 23. 220-62-3722 Austria Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at tXXYes 2 ☐ No Director Harford Aberdeen Maryland the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Нете 23а 56 Mr. Royal 21001 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2X No Specify: Specify: δ 3 Widowed 4 □ Divorced White "natural" Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) 8 home maker in home 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any illury or other traumatic event 908. 17. Father's Name (First, Middle, Last) Be Maria Elizabeth Fochter ဥ Joseph Loibl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 57, Unionville, PA 19375 Carol A. Hinch (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☑Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) 5/6/2010_ R.A Ferris & Company West Chester, PA 22. Name and Address of Facility
Tarring-C
Aberdeen, Maryland 21001 21. Signature of Funeral Service Ligensee Cargo FuneralHome, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SHOCK **Physician** /Medical Due to (or as a consequence of) Examiner BRADY CARDIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of The law requires that the death certificate be executed nding physicien and that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 Z No 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 No 2 No 1 Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 1 ☐ Yes 2 Z No 2 ER/Outpatient 3 DOA this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. filled in by the fi 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 29c. License number 5-6-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PUTMAWALA AVE., HANDE de GRACE, MD S. UNION 501 32. Degistrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month maco 9:25 AM Medical 4a. Facility Name (if not institution, give street and number) or Location of Death Examiner 4b. City, Town, 4c. County of Death Maryland Baltimore Ch 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (th yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min. 1**X** M 2 □ F Country) Director 213-54-0633 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location Ħ 10d. Inside City Limits filed within 72 hours after death with the Maryland Director or than "natural", or items 23a or 28a-f s the Medical Examiner must be notified 1 X Yes 2 No Baltimore MD NA 10e. Street and Number 10g. Citizen of What Country? Funeral 4358 Shamrock Ave 1st Floor 21206 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Never Married 2 Married Completed by 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) March Funeral 2th_grade <u>Funeral</u> Assistant Homes Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edith Johnson Robert Hinton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Hinton-Brother Yellowwood Ave, Baltimore, Md 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Department of I 1 🗌 Burial 2 💢 Cremation 3 🗌 Removal from State injury or On-Site 4 Donation 5 Other (Specify) 5/07/10 Baltimore, Md 22. Name and Address of Facility
March F/H West
4300 Wabash Av 21. Signatule of Funeral Service Licensee 21215 Ave. Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ tai disease or condition resulting in death) Heart Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Examin the burial-tran that initiated events The law requires that the death certificate be exec Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death 2 🗌 No ed by the a detached f 9 Unknown 1 ☐ Yes 2 L 9 ☐ Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Yunknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Physician: director, Be 25. Was case referred to medical of Vital 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 5 Pending Division 1 Yes 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) AU4176435618276 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6th Floor suite 200 Baltimore MOZIZOI 110 S. Paca (3/25 by

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#20b, perFH, G903, 5/12/2010, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ Day 2010 Year 12, 1:48 Рм Donald Francis Hart Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number 7. Age (In vrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Ye
November 3, 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Min. Months Days Hours Director 021-26-1914 75 Massachusetts Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20814 115 North Brook Lane United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forces?
1 X Yes 2 ☐
If Yes, Give Black, White, etc. rces / 2 No 1956 Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify:White 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Foreign Service Officer U.S. Department of State Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Bartholomew Hart Ariel Morse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linette Hart/Wife 115 North Brook Lane, Bethesda, Maryland 20814 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Maryland Veterans Cemetery May 14, 2010 Crownsville, Maryland . Signature of Funeral Service Line 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 Houn May M01530 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) oronac Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 🗌 Inpatient 2 🖳 Certificate: To ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Sulcide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) April 13, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Matthew Leonard, M.D. 8600 Old Georgetown Road, Bethesda, Maryland 20814 31. Date filed (Month, Day, Year) . Registrar's Signa State Registrar DHMH 17 Rev 7/2009

Donald

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 200 18:50 M IAN Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** RANDAUSTON Timeny NONTHWEST HOSPITAL CENTER 7. Age (In yrs. last birthday) 89 Yrs. if Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 KF Hours Months Days Min (Month, Day, Year, Marryland 218-03-9389 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10c. City, Town or Location 10a. State ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director 1 🗌 Yes 2 🔀 No Baltimore Eastwood Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21224 Funeral 7205 Gough Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 😾 No If Yes, Give <u>6</u> Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic current. College (1-4 or 5+) Elementary/Seconday (0-12) Textile Seamstress Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Czajkowska Rose ည John Zakoscielna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1049 Winsford Road Towson, Md. Raymond M. Jozwiak(son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition May 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 7, 2010 Baltimore, Maryland 4 Donation 5 Other (Specify) Rosary Cem 22. Name and Address of Facilit Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licer Md.21222 Dundalk Avenue Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence or) if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Year 5 Other (specify) Pregnant at time of death After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 Yes 🗌 Yes 2 😾 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) completed filled in by the funeral director, Be Other: 2 1 No 1 Inpatient 2 ER/Outpatient 3 IDOA 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Natural 5 Pending 2 🗀 No Accident Suicide Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the Pwithin 2 To the P only one) 29b. Signature and title of certifier

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month George Yessler Jordy 30 pri1 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery <u>Shady Grove Adventist Hospital</u> Rockville Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
May 2, 1932 9. Birthplace (State or Foreign Country) Pennsylvania 7. Age (In yrs. last birthday) **Funeral** 1 **X** M 2 □ F Min. Months Days Hours Director 183-24-3467 Usual Residence of Decedent Show 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Montgomery Montgomery Village Maryland| 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20207 Grazing Way 20886 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2X No Black, White, etc þ 1 Never Married 2 X Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Completed Year or Dates White er than "natur t, the Medical E Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry completed) (Give kind of work done during most of working life. DO NOT use retired) (Specify only highe Elementary/Seconday (0-12) College (1-4 or 5+) United States Government Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mary Yessler George Louis Jordy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20207 Grazing Way, Montgomery Village, Maryland 20886 Judith Ann Jordy/ Wife If item 2 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State May 2 ☐ Burial 2 K Cremation 3 ☐ Removal from State Important: If any injury or permit. Page Department 4 Donation 5 Other (Specify) Montgomery Crematorium, Inc. 2010 Bethesda, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. Athay Par M01360 300 West Montgomery Avenue, Rockville, Maryland 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ Cardiac Dysrhythmia Years disease or condition resulting in death) Medical Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi Aortic Stenosis and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant a Pregnant at time of death 5 Other (specify) 2 No detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ped 23e. Did tobacco use contribute to the cause of death? Completed by within 24 hours after death.

To the Funeral Director: After this certificate has been signe completed filled in by the funeral director, page 2 should be o 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🕅 No မ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 \square Pending work? X Natural Accident Investigation 3
Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 2 Medical Examiner: On the pasis of examination and so infossignation, and operating Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) April 27, 2010

State Registrar

DHMH 17 Rev 7/2009

9901 Medical Center Drive, Rockville, Maryland 20850

address of person who completed cause of death (Item 23a) (Type, Print)

110**>**

32. Registry 's Signature

David Srour, M.D.

34. Date filed (Month, Day, Year)

20	10	-	3	

		1- For State Registrar			Cert	ificate of L	Death		Re	g. No.	10 1404
Physici		1. Decedent's Nam	e (First, Midd	le,Last)		- /		2	Date of Death		3. Time of Death
Medical Exami	ner	Anne	tte	Mar	re Je		n		May 4, 201	0	0945 hrs
		4a. Facility Name (on, give street and no ot 1269	umber)		City, Town, or Location Rockville	n of Death		4c. County of D Montgomei	
Funeral		5. Social Security I	Number	6. Sex	7. Age (In yrs. las			nder 24Hrs.	8. Date of Birth		. Birthplace (State or
Director		228-13- Usual Residence of		1 M 2 KF	37	Yrs.	Months Days Hou				Country) FL
any		10a. State	10b, County	/		own or Location			-		10d. Inside City Limits
Maryland 28a-f show any d at once.	ctor	MD 10e. Street and Nu	Mon7	gomer	K	ockvi	Of. Zip Code		I 10	g. Citizen of What 0	1 X Yes 2 No
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland lealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once.	al Director	198 F	talp.	ine Sti	reet Ap	+ 1269	2085			US	A
death wi	Funeral	11. Marital Status 1 Never Marri		arried Armed F	2 🔀 No	If Yes,	Decedent of Hispanic O specify Cuban, Mexica	an, Puerto Ri		14. Race - Ar White, et	merican Indian, Black, c.
s after ral",	by	3 Widowed		orced If Yes, Give Yea or Dates:			es 2 No specif			Specify:	Black
hour natu Exan	ed ed	15. Decedent's E		cify only highest gra-			Usual Occupation (Giv of working life, DO NO			16b. Kind of Busine	ess/industry
21215-0036 uld be filed within 72 Mental Hygiene. marked other than '	Completed	Elemental y/Seco	oridary (0-12)	5	+	H15	5 Speci	ialis	+	NI	H
e, MD 21215-00; 1 and 2 should be filed with Health and Mental Hygener item 27 is marked other th	S	17. Father's Name	(First, Middle,	Last)	-		18.Moth	er's Name (F	1	aiden Surname)	
2121 uld be fi Mental I marked	Be	19a. Informant's Na	2 James/Pelations	ONNSON	Jr.	10b Mailing A	ddress (Street and Nu	1115		raine	
MD 2 d 2 shou lth and N n 27 is n	٩	W/1/1/	John.		father)	1/2/205			0	nbroke t	Pines FL 33028
e, ML 1 and 2 s Health an item 27	ı	20a. Method of Dis	position		20b. Pla	ace of Disposition	n (Name of cemetery,		Date	20c. Location - City	or Town, State
Baltimore, permit. Pages 1 an Department of Hes important: If ite		1 Surial 2 Donation 5		3 Removal fr	om State	Sour	th Меногіа!	15-1	5-10	Minni	FL.
Baltimo permit. Pag Department Important: injury or of	1	21. Signature of Fu			1000	22. Nam	ne and Address of Facil	lity	ineral	Services	, , _
_ =====	_	Vaugh		. Drew	ll	1710	i Gumon a	30/1 M	veriae	(2122	
Physician /Medical	1	failure. List on	e disease, or ly one cause	on each line. Cut	tting wou	nds of	mode of dying, such as upper extr	emitie	spiratory arres	st, shock, or heart licated b	Approximate Interval Between Onset and
Examiner		Immediate Cause (or condition resulting			nydramine consequence of):	intoxi	cation				Death
		Sequentially list co	nditions,	b	,						
	aminer	if any, leading to im cause. Enter Under	rlying Cause	Due to (or as a	consequence of):						
od Isit	Exam	(Disease or injury to events resulting in		Due to (or as a	consequence of):						
ecute and - trar		V		d							
760, cate be ex physician he burial	/Medical	X UNPENDED		AMENDED 23a	,27,28a-f	,per ME	G903 5/24	/10 TT		Tana a salah	
8760, tificate b ng physic as the bur		IF FEMALE: 23b. Was decedent			outcome of pregnar irth	ncy 2 Fetal	death 3 Ectop	oic pregnancy	/	23d. Date of deliver Month	very Day Year
Box 68's death certification attending defor use as	sicia	past 12 months 1 Yes 2 V		4 Pregn	ant at time of death		(Specify)				
D.O. BC that the des ned by the si detached fo	Physiciar			9 Unkno		Ilting in the unde	erlying cause given in F	Port I	23e Did tob	acco use contribute	to the cause of death?
on of Vital Records, P.O. Box 68 anding Physician: The law requires that the death certifuth. r: After this certificate has been signed by the attending to fineral director, page 2 should be detached for use as	2	r art ii. Other signi	ilcant conditi	ons contributing to	death but not resc	ining in the unde	enying cause given in r	art I.			Probably 4 Unknown
ords, w require s been si	Completed						-		24a. Was an		autopsy findings available
e law e has l	E E								autopsy perform	ed? death	
tal Rec		25. Was case refer	ed to medical				26.Place of Death	(Check only	1 Yes 2	✓ No 1	Yes 2 No
Vital ysician: his certifi director,	Be	examiner?	2 No	Hospital: 1	npatient 2 EF	R/Outpatient 3			-	esidence 6 🗸 Ot	her: Scene
ion of tending Pheath.	\vdash	27. Manner of Deatl		28a. Date	of Injury 28 Day, Year)	Bb. Time of Injur	y 28c. Injury at Wor				ubject cut
. <u>∪</u> 2 3 5 ± 1	atio	1 Natural 2 Accident	5 Pend			d 9:37	am 1 Yes 2 X	I NO I	us and Ug	wrists a	nd took
Division of Vital Records, rate or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	Certification:	3 X Suicide	6 Could	not be 28e. Place	of Injury - At home residen		actory, office building, e	١.	or Town, Sta	eet and Number or te) 198 Ha1	Rural Route Number, City pine St. Ile, MD
ospita hours uneral		4 Homicide 29a. Certifier		(Openly)							
Division To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical				of examination and/		at the time, date and p in my opinion, death o		,		
F > F o	ž	29b. Signature and	title of certifie		MARK	U	29c. License number	r		29d. Date signed (#	Month, Day, Year)
M		Occlo	2 8/4	londe	el I		O.C.M.E.			May 5, 2010	
3		30. Name and addre Victor Weed		who completed caus Assistant Med	e of death (Item 23 dical Examiner		n Street, Baltimor	re, MD 21	201		
Sta Regist	100	31. Date filed (Mont	Y 0, 79 ar 2	010 Jan	gistrar's Signature	barks	,		_		
DHMH 17 Rev 1/20				ICME		DEICHAL					

				Department of Health and Certificate of Death			14346
			Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg.		3. Time of Death
	Physicia		Catherine Margaret Jarkowski		Month	Day Year 1 30, 2010	12:30 AM
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea		4c. County of Death	
		•	Stella Maris Hospice	Luthe	rville	Baltimore	e
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Months Days Hours Mir		9. Birthplac	ce (State or Foreign
н	Director		212-36-3827	Yrs. World S Says Flours Will	o. (Month, Day, Yea Oct 26	, 1938 Mar	yland
	nd how at	ř	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location		10d	I. Inside City Limits
	laryla 3a-f s ified	ect	MD Baltimore Dung	dalk			1 ☐ Yes 2 🗡 No
	or 28	Ö	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country	/?
	with s 23a ust b	Funeral Director	1776 Stokesley Road	21222		United Sta	ites
	death item		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- rto Rican, etc.)	14. Race - American	
36	after I", or xamil	Completed by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates.	1 Yes 2 No Specify:		Black, White, etc	
8	atura cal E	etec		Decedent's Usual Occupation	166	b. Kind of Business Indus	hite
75	an "n Medi	mpl	(Specify only highest grade completed)	(Give kind of work done during most of wi life. DO NOT use retired)	orking	s. Kind of Business indus	stry
212	withir giene er the		Elementary/Seconday (0-12) College (1-4 or 5+) 1.2	Homemaker		Own home	
nd	filed al Hy d oth) Be	17. Father's Name (First, Middle, Last)	18. Mother's N	ame (First, Middle, Maide	en Surname)	
yla	Ild be Ment larke	욘	George William Toth	Marg	aret Rupp		
Jar	shou and r			Mailing Address (Street and Number or F			
e)	and 2 Healtl em 2 ther t		Jeanne Jarkowski /Daughter 20a. Method of Disposition 20b. Place of	3312 Woodspring Dr			
nor	nt of nt of t: If it		1 Durial 2 Cremation 3 Removal from State cemeter	y, crematory or other place)	May 03,	Location - City or TownBeltsville,	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		Od Claustina of Financial Consider Lieganos	apeake Crematory 22. Name and Address of Facility	2010	Bertsville,	Maryiand
Ba	permit Depar Impor any in once,	8 3	Roberta Acceleration Mo 158	Cremation and Fu			nd 21286
			23a. Part 1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.			A	pproximate
4	hysician/	82 9	Immediate Cause (Final disease or condition	DOC C			nterval Between Onset and Death
	Medical Examiner		resulting in death) a. Due to (or as a consequence of	f):			
		r.	Sequentially list conditions, b.				
	sit of	nine	if any, leading to immediate Due to (or as a consequence of cause (Disease or linjury	f):			
	and and I-tran	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of	f):			
0	icate be executed physician and sthe burial-transit	dical					
3760	ficate g phy: as the	/edi	_ u.				
Division of Vital Records, P.O. Box 687	endin	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ Fetal death	3 Ectopic pregnancy		23d. Date of delivery	
B 0)	death ne ath ed for	Sici	1 Ves 2 No 4 Pregnant at time of death	5 Other (specify)		Month Da	ay Year
o	at the	Phy	9 Unknown Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I	22a Did tahana	co use contribute to the o	aguag of dooth?
Ω.	es this signed be d	Completed by	Take in Other Significant Contractions South Editing to Godate Edit not recovering in	The allocitying sadds given in tall in	11	2 No 3 Probab	
rds	requir Deen (etec			24a. Was an	24b. Were autopsy	
ecc	The law cate has I	ldm			autopsy performed	prior to comp death?	bletion of cause of
<u> </u>	n: Th fficate or, pa		25. Was case referred to medical	26. Place of Death (Ch	1 Yes 2	No 1 ☐ Yes 2	□ No
/ita	/sicia s certi	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Ou	_ Other:	Home 5 Residence	6 Other (Specify)	
of	g Phy er this neral o		27. Manner of Death 28a. Date of injury 28b. T		28d. Describe how in		
on	endin sath. yr: Aff	fica	2 Accident Investigation	M 1 Yes 2 No			
VİSİ	or Att fter de irecte n by t	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined building, etc. (Specify)	m, street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Ro ate)	oute Number,
٥	ours a						
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within E4 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifler 1 Certifying Physician: To the best of my knowledge, concerning the Check 2 Medical Examiner: On the basis of examination and/or	investigation, in my opinion, death occurre	d at the time, date and pla	ace, and due to the cause	
	of the vithin of the somple	Σ	only one) 3 LX Certifying Nurse Practioner: To the best of my knowledge. 29b. Signature and title of certifier	29c. License number		Date signed (Month, Day	
			Innife hay car	45762		4130/2	
			30. Name and address of person who completed cause of death (Item 23a) (I				
					ONIUM, MD 2.	1093	
	Stat		31. Date filed (Month, Day, Year) MAY 0 7 2010 32. Redistrar's Signature	barks			
	Registra	al T	MAIUIZUIU JERUNG JS.	67			

DHMH 17 Rev 7/2009

12:00 A.M.

APRIL 30, 2010

CATHERINE JARKOWSKI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		,	1 - For Amend Item Registrar	State of Maryland / ns 16a,b per fh,	Dena 903 Cert	rtment9520 ificate of L	Pealth and Death	Mental Hygi	ene eg. No. 20	0 4347
	Physicia Medic		1. Decedent's Name (First, Middle, Las. RAY 8HAWN	A. JONES				2. Date of Death Month		3. Time of Death 7:40 AM
	Examir		4a. Facility Name (if not institution, give	street and number)		4b. City, Town, or	Location of Deat	h	4c. County of De	
	Funeral Director		5. Social Security Number 6. Se 217 - 69 - 6583	X 7. Age (In yrs. last bi		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day,	Year) 9. E	Sirthplace (State or Foreign Country) USA
	yland f show ed at	ctor	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tov	vn or Loca					10d. Inside City Limits
	a or 28a- be notifie	Funeral Director	MARYLAND 10e. Street and Number 5 SUMMER			10f. Zip Code	21207	10	Og. Citizen of What (1 🗆 Yes 2 🗆 No
	death with items 23 ner must	Funera	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. W	as Decedent of Hi Yes, specify Cuba	Ispanic Origin? (Sp	pecify Yes or No-	14. Race - An	
900	urs after o tural", or al Examir	ted by	1 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.		☐ Yes 2 🗹 No			Specify: AF	ite, etc. RO AMERICAN
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest grade) (Elementary/Seconday (0-12)	College (1-4 or 5+)	(Give ki	ent's Usual Occupa nd of work done of NOT use retired) lent	ation during most of wor	king	6b. Kind of Busines	s Industry tudent
and 2	be filed wi ental Hygia ked other c event, t	To Be (17. Father's Name (First, Middle, Last) RUSSELL	TARON JONES	\$ <u>\$</u>	R.	18. Mother's Nar	me (First, Middle, Ma	aiden Surname) MELIA	JONES
Mary	1 and 2 should be if Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Ty)		b. Mailing		and Number or Ru	ral Route Number, C	City or Town, State, 2	Zip Code)
Baltimore,			20a. Method of Disposition 1 Bural 2 Cremation 3 C	Removal from State 20b. Place comete		tion (Name of atory or other place	,		0c. Location - City of	or Town, State NJY. MD.
Baltir	permit. Page Department (Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Farteral Service License	101553	22.	Name and Addres		4905 907 BaHirir	K Road	
	ŢĬ.		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on Immediate Cause (Final	lications that caused the death. Do			g, such as cardiac		1	Approximate Interval Between Onset and Death
	Physician/ Medical Examiner		disease or condition resulting in death)	a. Due to (or as a consequence	of):	Dise	10750			Onost and Boatin
	sit sit	Examiner	Sequentially list conditions, if any sealing to immediate cause. Enter Underlying Cause (Disease or iinjury	 Dise to (or as a consequence 	Uf:			RAL PA	ZSY	
	cate be executed physician and the burial-transit		that initiated events resulting in death) Last	Due to (or as a consequence		, , , ,	00,000			
200	ficate g phys	Nedical		d					1	
. BOX 08	To the Prospital or Attending Physician: The law requires that the death certificate be executed within 24 hours fard death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnancy Other (specify)	у		23d. Date of d Month	elivery Day Year
S, F.O.	res that the signed by detaction	কু	Part II. Other significant conditions con (i) develop mer		in the und	derlying cause give	en in Part I.			to the cause of death?
Vital Records,	law requi has been e 2 shoul	Completed	2) Tonisellect	Long & Ade	noi	dectorny		24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
֟֟֝֞֟֝֞֝֞֝֞֝֞֝֞֝֞֝֞֞֞֞֞֞֞֞֞	in; The ifficate or, pag		25. Was case referred to medical			26 Pla	ice of Death (Chec	performed 1 Yes 2	ed? death? No 1 \(\sum Ye	es 2 🗷 No
N 15	lysicia is cert direct	To Be	examiner? 1 ☐ Yes 2 🗷 No	ospital:	utpatient	Othe	r·		ce 6 Other (Spe	cify)
on or	ending Phatath.	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury 28b.	Time of injury	28c. Injury work?	at	28d. Describe how		
DIVISION OF	tal or Atter tal or after the all Directo ed in by the	Certi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	arm, stree	t, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
	the Hospi nin 24 hou the Funer npleted fill	Medical	only one) 3 Certifying Nurse	cian: To the best of my knowledge, er: On the basis of examination and/o Practioner: To the best of my know	or investig:	ation, in my opinior	n, death occurred a	at the time, date and	place, and due to the	cause(s) and manner stated.
	Niti To			medung mo		29c. License	01101		d. Date signed (Mon	
	2		30. Name and address of person who co	profeted cause of death (Item 23a) (40	Type, Prir	ROTU	(N)A	429 B	alh. 212	71
	State Registra	-	11. Date filed (Month, Day, Year)	32. Registar's Signature	1. 4	back			_	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Florence Elizabeth Jackson Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Doctor's Community Hospital Lanham Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🛣 F Months Days Hours Min. April 14, Director 225-66-7749 Virginia 1949 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10b. County Director 10c. City, Town or Location Maryland Prince George's 1 ☐ Yes 2X No Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6880 Riverdale #822 Road 20706 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Baltimore, Maryland 2121 life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Samuel Johnson, Sr. Madeline E. Tyler 19a. Informant's Name/Relationship (Type, Print) (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6880 Riverdale Rd. #822 Lanham, MD 20706 Arthur Artie Jackson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burjal 2 Cremation 3 Removal from State Culpeper Nat'l Cemetery 5/6/10 4 Donation 5 Other (Specify) Culpeper, VA Sign Jure of Ineral Service Livensee 22. Name and Address of Facility Preddy Funeral Home 301 S. main St., Go Gordonsville, VA 22942 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or linjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No this certificate 2 No 1 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital. ျာ 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) eral Director: After th filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined within 24 hours a

To the Funeral C

completed filled Medical 29a, Certifier 1_certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6-00d ROAD

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Regis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** May 5, Helen 2010 Kupris 2:45 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Arcola Health & Rehab Silver Spring Montgomery 8. Date of Birth (Month, Day, Year June 13, 1 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Days Min. 1 M 2 F 169-28-6588 94 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No MD Director Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 39 Kingsman View Cr. 20901 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify 2 White 3X Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Michael Desko Helen (unknown) ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Elaine Beck (Daughter) 637 N. Rebecca Avenue Scranton, PA 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 ☐Removal from State Cathedral Cemetery 5/11/10 Scranton, PA 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature Funeral Service Dicenses Solfanelli-Fiorillo Funeral Home 1030 N. Main Street Scranton, 18508 PAPart). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immedia e Cause (Final Metastatic Gall Bladder Cancer 2 months **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter processing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending properties for use as 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an funeral director, page 2 s performed? 1□ Yes 2□ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident filled in by the 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D09834 May 6, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barry Rosenbaum, MD 3720 Farragut Avenue Kensington, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10:47 A M Frances Sue Khawaja May 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Rosedale Franklin Square Hospital 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** (Month, Day, Year) V • 4, 1947 Days Hours Min. 1 □ M 2 🕱 F 245 74 9205 62 Virginia Yrs. Director Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at with the Maryland Director Baltimore 1 X Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21205 USA Funeral 929 Horners Lane Page 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
sant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black White etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Restaurant Waitress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Osie Adkins 2 Curlon John Harvey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 929 Horners Lane Baltimore, Maryland 21205 Fannie J. Coe (Sister) permit. Page 1 and 2: Department of Health Important: If item 27 any injury or other troones. Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Baltimore, Maryland 1

Burial 2

Cremation 3

Removal from State Bayview Crematory inc. 5/7/2010 4 Donation 5 Other (Specify) 21. Signature of Full and Send Tip of ee 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Respiratory Failure Approximate Interval Between Onset and Death Respiratory Failure Physician/ disea or condition resumg in death) Medical Due to (or as a consequence of) Examiner **Emphysema** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Dav Year Pregnant at time of death Yes 2X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Lung Cancer 1X Yes 2 □ No 3 □ Probably 4 □ Unknown Records. Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Be examiner? Hospital Other: 2 🔀 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes ည 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After X Natural injury work? 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after death To the Funeral Director: ocmpleted filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) a del MSSON 9106 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Dav Year Louis Michael Karpouzie May 2010 6:45A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6101 Hamilton Avenue Rosedale Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 XM 2 □ F 216-20-6788 Director 84 March5.1926 West Virginia Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f shov York Pa. Director Glen Rock 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14027 Taylor Hill Road 17327 Funeral U.S.A. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1¶TYes 2 □ No IfYes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) Coordinator Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than, Elementary/Secondary (0-12) 12th College (1-4or 5+) Hygiene, City of Baltimore Special Events is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Michael Karpouzie Maria Baouris 19a. Informant's Name/Relationship (Type. Pin aughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If Item 27 is
any injury or other trau
once. Lisa M. Karaskordas 14027 Taylor Hill Road Glen Rock, Md.17327 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 □ Burial 2 □ Cremation 3 □ Removal from State Oak Lawn Cemetery 7, 2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Kaczorowski Funeral Home. PA Robert 1201 Dundalk Avenue Baltimore, Md.21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Dane Melastasis Immediate Cause (Final Renal (ell Cancor. Physician an- Known disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been signed should be 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page perform certificate 1 □ Yes 1 ☐Yes 2 ☐No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this funeral 27. Manner of Death

Natural

Control

Accident 28a. Date of Injury (Month, Day, Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 □Yes 2 □No the f within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number D – 38754 29d. Date signed (Month, Day, Year) M.D. 05-05-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 709. EASTERN BLVD - MD-21221 MALKA NASEBM

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

10-03337 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Micheal Laubach 1. For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day April 30, 2010 Medical Examiner 1917 hrs MICHAEL STEPHEN LAUBACH 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Harford Upper Chesapeake Medical Center 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Funeral Country) Days Months Hours Min Director 219-04-5418 1 × M 2 F 26 15. Nov. Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 X No 28a-f show narked other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at once. Maryland Harford Street permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 3125 Queens Castle Court Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-11. Mantal Status 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2 X No Yes 3 Widowed 4 Divorced If Yes, Give Year Yes 2 X No specify: Specify: White þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Automotive 10 Mechanic 18.Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Charles William Laubach Constance Darlene Wheat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 is Baltimore, MD Constance D. Puleio 3125 Queens Castle Ct., Street, MD 21154 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date crematory or other place) 12, X Cremation Burial Hilltop Service Corp. 4// Donation 5 Other Specify 5-11-10 Towson, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Rd., Abingdon, MD
disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and tran: Physician/Medical attending physician or use as the burial UNPENDED **AMENDED** The law requires that the death certificate be IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been ector, page 2 should 24a, Was an Were autopsy findings available prior to completion of cause of autopsy performed? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be Other4 Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 Nursing Home 5 Residence 6 Other: DOA After this 1 Yes No 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician: I Director: within 24 hours after death. To the

4 Homicide determined (Specify) Major Road / Highway	or Town, S Route 40 Wes	tate) stbound/Pamela Drive, Abingdon, MD
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred a	at the time, date and place, and due to the caus	e(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, and manner stated.	in my opinion, death occurred at the time, date	and place, and due to the cause(s)
9b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
A 15 11 11 11 11	O.C.M.E.	May 1, 2010

1826 hrs

28e. Place of Injury - At home, farm, street, factory, office building, etc.

30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner

Apr 30, 2010

111 Penn Street, Baltimore, MD 21201

1 Yes 2 ✓ No

32. Registrar's Signature 31. Date filed (Month, Dev Year) Registrar

5 | Pending

Investigation

27. Manner of Death

1 Natural

2 🗸 Accident

Certification:

Medical

Motorcyclist to van collision

28f. Location (Street and Number or Rural Route Number, City

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May Day 2010 Pear John Joseph Maggio 3:00a Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death more 4b. City, Town, or Location of Death **Examiner** Riverview Nursing Center Essex 8. Date of Birth (Month, Day Yea June 14 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** 214-16-3245 1 🔀 M 2 🗆 F Country) Director 96 June 191B MD Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Director Baltimore Baltimore MD 1X Yes 2 No 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Washington Street Funeral 221 S. 21231 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinant in þ 1 Never Married 2 Married 1 X Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 XWidowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore City Surveyor 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Angelina Cicero Theodore Maggio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4402 Lobelia Road Balto. MD 21236 Angelina Taylor /niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 5/12/2010 Baltimore MD Holy Redemeer 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signatural Luperal Service Licenses 300 Mace Ave. Balto. en Connelly Funeral Home of Essex 23a. Part 1. Enter the disease or c shock, or heart failure. List of emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) umon month Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of, Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Pregnant at time of death Other (specify) 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No y pertensin 24a. Was an After this certificate has funeral director, page 2 autopsy performed? Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital 1 \square Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending within 24 hours after death. To the Funeral Cirector Af 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

· Mace Ave., Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 05 MARY **JOANNE** MEKINS 0 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death UNION MEMORIAL HOSPITAL BALTIMORE N/A Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8 Date of Birth Funeral 1 - M 2 - F Months Days Hours 0470171942 218-36-6322 MARYLAND Director 68 Yrs Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at 10a. State should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 3529 ROLAND AVENUE 21211 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Completed WHITE permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOUSEWIFE DOMESTIC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JULIAN CARTER BROWNLEE BERTHA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOSEPH MEKINS/ HUSBAND 3529 ROLAND AVENUE, BALTIMORE, MD 21211 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BAYVIEW CREMATORY 5/5/10 BALTIMORE, MARYLAND 21. Signature of Fundamental Licenses TLY ACCEPTER INC. FUNERAL HOME 001 EASTERN AVENUE, BALTIMORE, MD 21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Pnysician. Medical resulting in death) **Examiner** ile Sequentially list conditions, if any, leading to immediate cause. Enter Underlying CERTIFICATION APPROVED BY MEDICAL EXAMINER Examin Cause (Disease or iinjury that initiated events resulting in death) Last burial-transit Due to (or as a consequence of): physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ morehage - Su Soural hematon 1 ☐ Yes → No 3 ☐ Probably 4 ☐ Unknown Completed (Spontaneous) 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed? Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ၉ Inpatient 2 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pendina Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier "Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Prantioner: It the best stray knowledge death conumed at the time date and plane and due to the cause(s) and manher as stated 29c. License number D 00 15462 29b. Signature nd title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

Registrar

200 E.33 MST #640 BALTON MD 21218

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MIGUEL KARACUSCHANSKY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month GERALDINE MOORE 7.30 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** <u>Levindale Nursing Home</u> Baltimore If Under 24 Hr 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔽 F Months Hours Min Director 85 Usual Residence of Decedent f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. In portant: If item 27 is marked other than "natural" or item on 27 is marked other than "natural" item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 4916 Lanier Ave #A 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. Never Married 2 Married 3 Widowed 4 Divorced Completed by Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🔽 No Specify: Black Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <u>12th grade</u> <u>Private</u> Domesti Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ <u>Maggie Lee</u> <u>Sam Moore</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy Mizell-Daughter
20a. Method of Disposition 4916 Lanier Ave #A, Baltimore, Md 21215 Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place)

Severn 1st Baptist

Church Cemetery 5/11/10 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State injury or Donation 5 Other (Specify) Severn, NC 22. Name and Address of Facility
March F/H West
4300 Wabash 21. Si mature of Funeral Service License. 300 Wabash 21215 Baltimore, Ave, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Dronay disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) cat has been signed by the attending physician and page 2 should be detached for use as the burial-transit execute that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? clopendent 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificat has been Deneusia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No completed filled in by the funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 은 1 Inpatient 2 ER/Outpatient 3 DOA After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide Investigation To the Hospital or Attend within 24 hours after deat To the Funeral Director. 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) snam D 068394 S S 10 W. D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Levi Adole Belondoe Derset Bal Krune 31. Date filed (Month, Day, Year) 21215 OWI

Registrar DHMH 17 Rev 7/2009

State

32, Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death nt's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Medical 4a. Facility Name (if not institution, give street and nur City, Town, or Location of Death **Examiner** 4c. Counfy of Death 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1**X**M 2□F Hours Country) **Director** or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 🗆 🍂 2 🗆 No 10g. Citizen of What Country? 6050 Moravia 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates Decedent's Education 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) conday (0-12) College (1-4 or 5+) Be Name(First, Middle Maiden Surname) မ 19b. Mailing Address (Street and Numb Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other p Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Donation 5 - Other (Specify) Signatur of Fundal rvice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially liet on officine, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine the Hospital or Attending Physician; The law requires that the death certificate be execute. and burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) 4 Pregnant
9 Unknown Pregnant at time of death the P.O. þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No Division of Vital Records, 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 5 Pending 2 No 1 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated License number 29d. Date signed (Month, ed cause of death (Item 23a) (Type, Print) Name and address of pe 31 Date filed (Month, Day Year State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>010</u> Physician/ Month James Leslie Muscelli 8:21 A M Mav Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2511 Banger Street Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Hours 1 1 - 4 - 1 9 4 7 Maryland Director 215-52-2964 Usual Residence of Decedent marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Md Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2511 Banger Street 21230 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married ₽ 1 X Yes 2 ☐ No If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 X Divorced Completed Year or Dates. Armv 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) uld be filed within 7 I Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Ray's Envelope Comp Press Operator 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Muscelli Ruth Agnes Morris injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) Brother and 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>.v</u> permit. Page 1 and 2 st Department of Health a Important; If item 27 is any injury or other tra Daniel W. Muscelli 2511 Banger Street Balto. Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State West Arundel Crem 5-9-2010 Odenton, Maryland 4 Donation 5 Other (Specify) 21. Signature Fyreral Service Lyensee 22. Name and Address of Facility Joseph N. Jr. F 21224 Zannino Conkling St. Balto. Md. S. 23a. Part 1. Enter the disease com ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. I st only Interval Between Onset and Death chronic obstructive Immediate Cause (Final Pul. Disease Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, cause. Enter Underlying
Cause (Disease or linjury
that initiated events Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 as attending p 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Yes 2 No 4 ☐ Pregnant 9 ☐ Unknown ed by the a 1 ☐ Yes 2 ☐ Unknown P.O. I signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, been signatures should be 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an certificate has b irector, page 2 sl autopsy 25. Was case referred to fhedical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Tyes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 \square Pending injury work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier male attamas 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Philadelphia, Rd. Suite (08, Balt, Md. 21257

Registrar

State

9114

32. Registrar's Signature

ATTANASIO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 1:55 PM Larry Lee McDaniel May 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Agnes ltimore Baltimore If Under 1 Year | If Under 24 Hrs. Social Security 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Number 7. Age (In vrs. last birthday) **Funeral** 1 X M 2 □ F Months Days Hours 234-86-0110 57 April 13, Director West Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural"; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exercises. 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County Director 1 □Yes 2\ No Maryland Montgomery Germantown 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 18900 Fountain Hills Drive 20874 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2X No Specify: ģ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Program Manager United States Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ Frank Arnett McDaniel Neva Claire Henry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grace P. McDaniel/Wife 18900 Fountain Hills Drive, Germantown, MD 20874 20b. Place of Disposition (Name of cemetery crematory or other place)
Montgomery
Crematorium, Inc. 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 10, 2010 Bethesda, Maryland 21. Signature of Funeral Service Robert A. Pumphrey Funeral Home/Rockville, Inc. cuen M01530 300 West Montgomery Avenue, Rockville, Maryland 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death senteneal vesothelions Immediate Cause (Final disease or condition resulting in death) Metastatic **Physician** 2 days /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). and Due to (or as a consequence of): of Vital Records, P.O. Box 68760, ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ð 4 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an 1 □Yes 2 No To the Hospital or Attending Physiciam. within 24 hours after death.

To the Funeral Director After this certifici completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1/Z Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature P23574 M.D. May, 4, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Battimore, MD 21229 CALVIN S 900 Coton Averve DAVID 31. Date filed (Month, Day, Year)

Registrar

McDanie

State

DHMH 17 Rev 1/2001

32. Registrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 9:47 P M May 1, 2010 Helen Edwina Minor Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery 5802 Nicholson Lane #1202 Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 F Days June 29 Yrs. 1921 Ohio Director 88 158-20-8885 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 X No Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20852 5802 Nicholson Lane #1202United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give 1 Never Married 2 Married Ş Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) armit. Page 1 and 2 should be filed withil epartment of Health and Mental Hygiene sportant; If item 27 is marked other the yinjury or other traumatic event, the Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elizabeth Snyder Edwin Dillhoefer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Illinois 60202 1020 Asbury Avenue, Evanston, John E. Minor / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant; If ite
any injury or other Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 7, 2010 Rockville, Maryland Parklawn Memorial Park 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Primary Sclerosing Cholangitis disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 3 🔲 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Contriving Nurse Practioner To the best of my knowledge, death occurred at the time, date and plane, and due to the consels) and him nurse stated ritir or 29b. Signature and litle of certifier 29c. License number D40216 May 4, 2010

State Registrar

DHMH 17 Rev 7/2009

parke

32. Redistrar's Signature

7625 Wisconsin Avenue, Bethesda, Maryland 20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis A. Cullen, M.D.

31. Date filed (Month, Da

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #30 State of Maryland / Department of Health and Mental Hygiene 14360 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day John G. Metzger Jr. 8:30 p M 2010 May Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 711 Umbra Street Baltimore N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign **Funeral** Days 1**火** M 2 □ F Months Hours Min. Country) 216-28-1628 78 **Director** December Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-5 are nijury or other traumatic event, the Madical Franciscopie. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Maryland N/A Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 711 Umbra Street 21224 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ρ 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Post Office Mailman 10 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret Gensler John G. Metzger Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 520 B. Riviera Drive, Joppa, Maryland 21085 William H. Metzger Brother 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) May 8,2010 Oak Lawn Cemetery Dundalk, Maryland ign ture of Funeral Service Licensee Connelly Funeral Home Of 7110 Sollers Point Road, Dundalk, P.A. Dundalk, Md. thone 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final INFARMION Physician/ MYOCAROIA disease or condition resulting in death) Medical Due to (or as a consequence of Examiner 5 YRS ARTERY PSIANDSO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Dav Year ☐ Pregnant at time of death☐ Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy performed 1 Yes 2 No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) filled in by the funeral . Manner of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work 1 ☐ Yes 2 ☐ No Investigation Accident after deat Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatur D5935 MAY 06, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4924 Campbell Blvd., Suite 200 Baltimore, MD 21236 Raymond H. Zollinger, MD 32. Registrar's Signature 31, Date filed (Month, Day State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Neumver **Physician** 21:41 Man 2010 03 bruce /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 215-32-5657 Aug. 6, 1937 Pennsylvania **Director** Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location show or 28a-f show notified at Harford Bel Air 1 ☐ Yes 2x No MD Director 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number , or items 23a or iminer must be r ō Pages 1 and 2 should be filed within 72 hours after death with USA 1410 Bonnett Place Apt.B 21015 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white Examir 1 Yes 2 No Specify Specify: þ 3 ₩ Widowed 4 Divorced "natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Medical (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene. 27 Is marked other than "r r traumatic event, the Med Social Security Administration Elementary/Secondary (0-12) College (1-4 or 5+) Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emma Wurst Herman Neumyer ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 Is any injury or other trau Scott Neumyer-son 822 Delray Drive-Forest Hill, Maryland 21050 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State May 8,2010 Bel Air, Maryland Bel Air Memorial 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Service 3 Newport Drive-Forest Hill, Maryland 21050 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Due to (or as a or nsequence of): arten **Physician** disease or condition /Medical resulting in death) **Examiner** Sequentially list conditions, if any teath cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to lor as a conse juence of or Attending Physician: The law requires that the death certificate be executed physician and is the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year atter I for in the past 12 months? Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 No 1 🗌 Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical Hospital: Other: 2 ER/Outpatient 3 DOA 4 Nursing Home 2 1 No 1 Inpatient 5 Residence 6 Other (Specify) 1 Tyes ၉ this 24 hours after death.

Funeral Director: After this letely filled in by the funeral 27. Manner of Death 1 Natural 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 28c. Injury at Work? Certification: (Month, Day Year) Injury 5 Pending investigation 1 Tyes 2 No 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospitai 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only within 24 the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES 000 May 03 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sin 600 North Wolfe St, Baltimore, MD, 21287 Davis 32/Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Beg. No.

			1 - State Registrar			,	Cer	tificate of			ionia ii	Reg. I	201	0	1.4	362	
П	D	,	Decedent's Name (First, Middle	e, Last)							2. Date of D	eath		,	3. Time	of Death	
	Physicia Medic		Minnie S. Ne	≥idi	ch						April	27 ,	2010 Y	/ear	9:38	P M	
	Examin	er	4a. Facility Name (if not institution					4b. City, Town, o				4	tc. County of	Death			
and the second			104 North Gra 5. Social Security Number	ndi 6. Sex			ast birthday)	Roc If Under 1 Year	kvi1	1e ler 24 Hrs.	8. Date of B	Birth 9. Birthplace (State or Foreign					
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350	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Mar 3 🛣 Widowed 4 ☐ Divorced	ried	Armed Forces 1 Yes 2 If Yes, Give Year or Dates.	? No		Nas Decedent of H f Yes, specify Cub I ☐ Yes 2 🔣 No			Rican, etc.)		Black, Specify:	White,	etc.		
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baltimore,	permit. Page 1 a Department of I Important: If ite any injury or ot	li	21. Signature of Funeral Service I					Name and Addre bert A. 0 West Mo	ess of Face Pump	hrey 1	Funera	1 Ho	me/Roc	kvi	lle,	Inc.	
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00 400	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No	23	c. If yes, outcom 1 Live Birth 4 Pregnant 9 Unknowr	n 2 ☐ Feta at time of d	I death 3	Ectopic pregnan Other (specify)	су			23d. Date of o			ery Day	Year	
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			Jeffrey Maziqu 31. Date filed (Month, Day, Year)	e, N				venue, N	W, W	ashing	gton,	D.C.	20012				
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 2010 1, 12:08PM Kathryn Gaynelle Porter Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Suburban Hospital Bethesda 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕇 F Months Hours Min. 0 1 2 7 7 1 9 4 5 Arkansas **Director** 64 414-78-2667 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must have acted. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1★ Yes 2 No MD Prince Georges | Upper Marlboro 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20772 10106 Georgian Lane USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: 3 Widowed 4 Divorced Black Year or Dates 15. Decedent's Education 16b. Kind of Business Industry
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1515 Hickman Mills Dr. P.P. Box 35186 June E. LaMothe/sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State Calvary Cem. 5/8/2010 Kansas City, MO 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Duane E. Harvey, Funeral Dri. . Signature of Funeral Service Licen 9100 Blue Ridge Blvd. Kansas City, MO64138 cc0278 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph sician/ Probable Atherosclertic Coronery Artery Distase Medical resulting in death) Due to (or as a consequence of) Examiner Obesity Sequentially list conditions, Examine Que to for as a do secuence of if any, eaching to in modificause. Enter Underlying Cause (Disease or iinjury Probable Non insulin Dependent Diabetes attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hyperlipidemia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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3 Suicide
4 Homicide Investigation within 24 hours after death To the Funeral Director: completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical * Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar Philip

31. Date filed (Month.

address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

Strauss, MD Suburban Hospital 8600 Old Georgetown, RD

D0044394

29d. Date signed (Month, Day, Year)

2010

May 1,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 2.29d per doc g904 6-8-10 vt.
State of Maryland / Department of Health and Mental Hygiene Amend Items 25,27,28a-f per me, 6903,05/97/2010dhb Reg. No. 2. Date of Death 27 Month Day 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year Physician Kamos Cristino April 3:36 AM 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6 Sex . Age (In yrs. last birthday) 8. Date of Birth **Funeral** Year) Days Min 1 🗶 M 2 🗆 F Hours Yrs. Director 563-82-7442 68 12/05/1941 Philippines Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🕱 No Director Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 8109 Pepper Ridge Way 20877 Funeral U.S.A 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No 1966 - Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 X Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: þ Specify: 3 Widowed 4 Divorced 1989 Asian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Stock Clerk United States Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jose Ramos ည Rosalina Encarnacion 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria Carlotta Ramos - Spouse 8109 Pepper Ridge Way, Gaithersburg, MD 20877 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington Natl. Cem. | 06/04/2010|Arlington, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Mo #1070 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat ause (Final disease or condition resulting in death) **Physician** acidosis lactic /Medical Due to (or as a consequence of): **Examiner** TERTIFICATION APPROVED BY MEDICAL EXAMINES. as a consequence of): Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury or Attending Physician: The law requires that the death certificate be executed nemmorhage and that initiated events burial-tra resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, ding physician Physician/Medical aortic Valve IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 X Yes Hospital: 1 Inpatient Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28c. Injury at Work? During re-do sternotomy and aortic valve replacement. 28a. Date of Injury 28b. Time of Certification: 24 hours after death. Funeral Director: After 1 Unknown M 5 Pending investigation 2X Accident 04/26/2010 1 Yes 2X No 3 🗌 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 600 N. Wolfe Street filled in by 4 Homicide **Hospital** Baltimore, MD Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) npletely and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number RES OOC April 26 - 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287

:041

State Registrar 31. Date filed (Month, Day, Year) NAY 0 7 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For Amend Item 22 State of Maryland (Department of Health and Mental Hygiene Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 05 Physician/ 04 2010 Silas B. Robinson 1:40 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 555 W. Towsendtown Blvd.(GILCHREST) Towsend If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 XM 2 □ F Hours 06/29/1924 238-24-4576 86 unknöwn Yrs. Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Baltimore City Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral Apt# 109 110 N. Central Ave. 21202 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 X No Specify: 3 Widowed 4 X Divorced Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Concrete Worker Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Wells Silas B. Robinson Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1321 N. Eden St. Baltimore, MD 21213 Helena Allen / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🔲 Burial 2 🙀 Cremation 3 🗆 Removal from State 5/6/2010 Hanover, MD Ardent Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ardent Cremation Services LLC 21. Signature of Funeral Service License 7522 Connelley Dr. #N Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Pedry Seath Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** NOVED BY MEDICAL EXAMINER Squartielly list on the insifer any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): CERTECATION Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year مند العلام page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1ematoma 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy perform Be 26. Place of Death (Check only one)

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.Ó. Box 68760 certificate within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di

25. Was case referred to medical examiner?
1 X Yes 2 \(\square\) No Manner of Death 1 Natural
Accident

Suicide

3 ☐ Suicide 4 ☐ Homicide

5 Pending Investigation 6
Could not be determined

28a. Date of injury (Month, Day, Year) April 22, 2010

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Unknown Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at work? 2 No

Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\foat{\text{N}}\) Other (Specify) 28d. Describe how injury occurred

on Rug 28f. Location (St. eet and Number or Rural e Number of Rural e Number o Num 110 N:(more

29a. Certifier (Check	1 Certifying Physician: To the best of my knowledge, death occi. 2 Medical Examiner: On the basis of examination and/or investigat 3 Continuing Nurses Fractioner: To the basis of my knowledge, death	tion, in my opinion, death occurred at the time, date	e and place, and due to the cause(s) and
29b. Signature at	nd title of certifier	29c. License number	29d. Date signed (Month, Day, Year,

29d. Date signed (Month, Day, Year)

son who completed cause of death (Item 23a) (Type, Print)

2120

2120

State Registrar

2

Certificate:

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Maryland / Department of Health and M 1 - State Registrar Certificate of Death		eg. No.	4355			
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Deat Month	th Day Year	3. Time of Death			
1	/Medic	al	James Raymond Rau, Jr. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	May	5, 201 4c. County of Deat				
	Examin	er	Carroll Hospice Dove House Westminster						
	Funeral Director			8. Date of Birth (Month, Day, Sep • 25	, 1924 Ma	hplace (State or Foreign untry) aryland			
	land	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits			
	death with the Maryland ms 23a or 28e-f ehow crivat be notified at		MD Carroll Westminster			1 ☐ Yes ※ ※ No			
	ith the	Olrec	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What Co				
	s 23s	Frail	201 St. Mark Way Apt.113 21158	naifu Van or No	U . S . A				
Maryland 21215-0036	ours after el', or Ite Exemine	by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 4 Divorced 1 Never Married 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify: If Yes, specify Cuban, Mexican, Puerto If Yes, Give Year or Dates:	Rican, etc.)	Black, Whit				
2	"natu	letec	15. Decedent's Education (Specify only highest grade completed) If a. Decedent's Usual Occupation (Give kind of work done during most of work) If b. DO NOT use retired.	ng	16b. Kind of Business	Industry			
212	be filed within 72 hc tal Hygiene. d other then "natur event, ihe Medicili	Completed	Elementary/Secondary (0·12) 12 College (1-4or 5+) Maintance		Mary1and	d Cup			
g	be filed ital Hygid d other event, II	Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, /					
<u>a</u>	should bent and Ment	2		e Fehr					
Mar	2 6 7 8		19a. Informant's Name/Relationship (Type, Print) Sister 19b. Mailing Address (Street and Number or Rura Beatrice Sienkiewicz / 201 St. Mark Way Apt.						
	s 1 and if Health Item 27 other tr		20a. Method of Disposition 20b. Place of Disposition (Name of		20c. Location - City or				
E	Pages nent of ant: If It ary or o		Parkwood Cemetery 5/8	3/10	Baltimor				
Baltimore,	permit. Pages Department of I Important: If It any Injury or of		21. Signature of Fundamental Service Licensee 22. Name and Address of Facility ECK 11605 Reisterstow						
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.			Approximate Interval Between Onset and Death			
)	Physician /Medical		Immediate Cause (final disease or condition resulting in death) List only one cause on each line. End 57age Reval V Due to (or as a consequence of): Sequentially list conditions. b. Dementially list conditions.	15 eas e					
	Examiner		nementia						
	ii o	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury						
	lificate be executed g physicien and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):						
09/89	e be e rsicien e burie								
_		Aedicai	TE FEMALE.						
O. Box	The law requires that the death certifi tie has been signed by the attending i age 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of de Month	ivery Day Year			
٦.	that the	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tol	bacco use contribute to	the cause of death?			
S S	quires tha	d by		1 🗆 Y	es 2 □No 3 □ P	obably 4 Unknown			
Records,	law requir	Completed		24a. Was a	an 24b. Were a	utopsy findings available completion of cause of			
				perförr 1 ☐ Yes	med? death? 2D No 1 ☐ Yes	2 □ No			
VIII	ysiclen: 7 is certifical director, p	To Be	25. Was case referred to medical examiner? \(\) 1 \(\) Yes 2 \(\) No \(\) Hospital: 1 \(\) Inpatient 2 \(\) ER/Outpatient 3 \(\) DOA \(\) Other: 4 \(\) Nursing Hoi	n <i>Check onl</i> √on me 5 ☐ Reside		city) Hespice			
on of	ding Phys h. After this funeral di		27. Manner of Death 1 SNatural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 1 1 28c. Injury at Work?		ow injury occurred	any mespice			
Division of	or Atten	Certification:	2 Accident	28f. Location (Si City or Town	treet and Number or R n, State)	ural Route Number,			
	To the Hospital within 24 hours a To the Funeral completely filled	Medical Co	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and the date a	and due to the cred at the time, d	ause(s) and manner a date and place, and du	s stated. a to the cause(s)			
	To the within 2 To the complete	¥.	29b. Signature and title of certifier 29c. License number	2	29d. Date signed (Mon	h, Day, Year)			
)			Mr. E. Walder D. M.V. 017154		05/07/	2010			
			30. Name and address of person who completed duse of death (Item 23a) (Typę, Print)	159	1 1				
3	Sta	te.	31. Date filed (Month, Day Year) 32. Registrar's Signature	120					
	Registr		MAY U' 7 2010 Deneva B. Janks						

n. chael 10-03216	John	Rogers
UNK UNK		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle Last) 2. Date of Death Physician/ Time of Death Month Day April 26, 2010 0635 hrs Medical Examine Michae 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 6011 Park Heights Avenue 2nd Baltimore 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Funeral oreian Months Days Hours Director 26 1 4M 2 F Country) minia Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b County 1 Yes 2 No s 23a or 28a-f show e notified at once. Virginia Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10e Street and Number 10g. Citizen of What Country 836 Westmins uneral 14. Race - American Indian, Black, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married Yes 3 Widowed 4 Divorced f Yes, Give Year 1 Yes 2 No specify: Specify ğ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surname Unknown Pegram 19a_Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Ro Number, City or Town, State, Zio Code) Diane Pratt Westminster 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Burial 2 Cremation 3 Removal from State Donation 5 Other Specify. 22. Name and Address of Facility 21. Signature of Funeral Service Licent 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician roximate Interval etween Onset and failure. List only one cause on each line Mudical Alcohol, cocaine and narcotic intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical X UNPENDED AMENDED 7,28a-f,per ME G904 6/21/10 TT Division of Vital Records, P.O. Box 68760, 23d. Date of delivery phy: IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year for use as past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene this 1 🗸 Yes 2 No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 1 Yes 2 No Pending Director: Fd 4/26/10 Fd 6:30 am 2 ___ Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6011 Park Heights Ave 2nd F1. BAltimore, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be Suicide within 24 hours a To the Funeral I determined (Specify) found in friend's house 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOME O.C.M.E. April 26, 2010 30. Name and address of person who completed cause of death (Item/23a) Assistant Medical Examiner Theodore M. King, Jr., MD. 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) Registrar's Signatur State Registrar

DHMH 17 Rev 1/2001 **OCME 2006**

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May 4 Physician/ 2010 10:20 A^{M} Allan Rabanales Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b, City, Town, or Location of Death Suburban Hospital Bethesda Montgomery 8. Date of Birth (Month, Day, Yea November 4, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Hours Guatemala 65 Director 219-54-8647 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 X No Maryland Montgomery Germantown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 23101 Davis Mill Road 20876 <u>United States</u> 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🗓 No If Yes, Give 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 🕅 Yes 2 🗆 No Specify: Guatemalan Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Real Estate Broker</u> Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Miguel A. Rabanales Candida Rodriguez off. Page 1 and 2 shours of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23101 Davis Mill Road, Germantown, MD 20876 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other i Elsie O. Rabanales/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery May 7, 2010 Silver Spring, Maryland Röbert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland Signature of Funeral Service Ligers 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Years Immediate Cause (Final Physician/ disease or condition resulting in death) Gastric Cancer Medical Due to (or as a consequence of): 2010 Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or imjury attending physician and that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death Other (specify) 1 Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2X No 3 ☐ Probably 4 ☐ Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Division of Vital Be (26. Place of Death (Check only one) 1 ☐ Yes 2 🗓 No ည 1 X Inpatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred XNatural injury 5 Pending Accident Investigation Suicide
Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 29a, Certifie 1 XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) MO D0066990 5/5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6420 Rockledge Drive Bethesda, Maryland 20817 10 Juneja, M.D. istrar's Signature State Registrar

DHMH 17 Rev 7/2009

10:20 am

allan

Rabanales

Amend 19a&b, per Fill g903 5/11/10 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician 2010 Carroll E. Smith /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Balti oseda tospita If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
April 8,1922 6/Sex 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months 1₩ 2□F Days Yrs. 215-12-7703 88 Maryland Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a, State 1 ☐ Yes 2 ☑ No Director Md Balto. Perry Hall 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a % H Brook Farm Ct. 21128 USA Funeral 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married XY944₽1946 1 ☐ Yes 2 No White Specify: Specify: 2 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Baltimore, Maryland 21215-00 $^{\prime\prime}$ Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Policeman Baltimore County filed v Hygie 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clara Klein 2 Carroll E. Smith 19b. Mailing Address (Street and Number of Burah Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print)
Launa
Laura F. Smith H Brook Farm Ct. Perry Hall, Md. 21128 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important; If Ite
any Injury or ott
once, St. Joseph Cem. 5-6-2010 Fullerton, Md 4 ☐ Donation 5 ☐ Other (Specify) Schimunek Funeral Home 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 9705 Belair Rd. Nottingham, Md.21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Hear disease or condition resulting in death) /Medical Disease Examiner oronari Sagas intally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 4□Pregnant at time of death Month Year in the past 12 months? 5 Other (specify) signed by the a P.0. 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? this certificate funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 27. Manner of Death 28a Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After i (Month, Day Year) or Attending 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 1 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral L To the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ress of person who completed ca<u>us</u>e of death (Item 23a) (Type, Print) Franklin SquareDrive Balto, Md 2/237 9000 Chandon State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 05-04-2010 Mark Charles Stewart 100 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 729 Laurel Rd Forest Hill Harford 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD 1 🛛 M 2 🗆 F Months Days Hours Min. 07422-1957 Director 216-68-4215 52 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2X No MD Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21050 729 Laurel Rd USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian. Armed Forces? 1 ☐ Yes 2 🗓 No Black, White, etc þ 1 Never Married 2 X Married hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give than "natural", 3 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) and Mental Hygiene. Branch Manager Keen Comp. Gas Co. item 27 is marked other other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Donald Stewart Ruth Billing permit. Page 1 and 2 shou Department of Health and Important: If item 27 is m any injury or other traum: 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly C. Stewart (Wife) 729 Laurel Rd Forest Hill, MD 21050 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 05-08-2010 ^{22. Name and Address of Facility} Schimunek Funeral nc 610 W. MacPhail Rd BelAir, MD 21. Signature of Funeral Service Licenses Home of BelAir 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Small cell & Cancer Immediate Cause (Final non Pnysician month disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Exam that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the burial Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death 5 1 Yes 2 No g Unknown the s been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has al director, page 2 autopsy Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 N Residence 6 Other (Specify) ပ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury ☑ Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)

Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or

> State Registrar

Medical

29a. Certifier

3 [

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2010

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUMAN RAD, 1103 FRANKLIN SOU 32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Som vARE DRIVE

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

5

29d. Date signed (Month, Day, Year)

21237

BALTIMORE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 5:30AM Rose Spatz 04 -8 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Locetion of Death 4c. County of Death Examiner Montgomery Bethesda Health and Rehabilitation Center Bethesda 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 XF Director 096-50-4347 82 Aug. 14, 1927 New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9205 Gatewater Terrace 20854 U.S.A. Funerai 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ② No Specify: White Specify: 2 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eugene Brasacchio Mary Grace Lanoce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tracy Spatz (Daughter) 6006 Melvern Dr., Bethesda, MD 20817 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Rood Cemetery 5/1/10 Westbury, NY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas A. Glynn & Son 21. Signature of Funeral Service Licensee 20 Lincoln Avenue, Rockville Centre, NY 11570 Part. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) a ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Unknown Examiner Due to (or as e consequence of): Examiner attending physician and for use as the buriel-trensit or Attending Physician: The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): of Vital Records, P.O. Box 68760. Physiclan/Medical Due to (or as a consequence of) resulting in death) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. é 1 ☐ Yea 2 ☐ No 3 ☐ Probably 4 ☐ Unknown End Stage Renal disease Be Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Hemodialysis completion of cause of death? Hypertension 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was cese referred to medical exeminer? 26. Place of Death (Check only one) Hospital: ဥ 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Division 1 Natural 2 ☐ Accident 5 Pending s after death.

I Director: Aff investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide Hospital 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hou To the Fune completely fi (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) brewde D43121 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHOWDHURY, MD; 1546 DINO DRIVE "BURTONSVILLE, MD 20866 31. Date filed (Month, Day, Year) 32. Regietrar's Signature State

DHMH 16 Rev 6/95

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25,27,28a-f per me, 9903,05/07/2010dhb

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4.27P M Month P21L 2000 05EPh Medical 4a. Facility Name (if not institution, give street and number) County of Death Examiner 4b. City, Town, or Location of Death KURNIE AHNE GLEN SACTIMOPE WASHINGTON MEDICAL GENTE Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Months Hours Director 23a or 28a-f show Department of Health and Mental Hygiene. Improvement of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10a. Citizen of What Country? by Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after timore, Maryland 2/215-0036 1 Yes 2 No Specify. Specify: whITE 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ONSTRUCTION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LARRY SPIRKO, 20a. Method of Disposition MD. 21032 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 4-16-10 ODENTON. MD. Sign / re sgherty Funeral Home 2601 MOUNTAIN RD. MASADIENA, 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ AIMOMINAM disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ACCIDENT YASCUL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine YON APPROVED BY MEDICAL EXAMINER ACTURED or Attending Physician: The law requires that the death certificate be executed and the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death Other (specify) the 1 ☐ Yes ∠ ☐ Unknown detached a Unknown signed by the vision of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been siy completed filled in by the funeral director, page 2 should to 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. injury at work? 1 ☐ Yes 2**X** No Certificate: 28d. Describe how injury occurred injury Natural 5 Pending 04/01/2010 2 X Accident Subject tripped and fell Unknown Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 619 Cedarwood Lane Crownsville, MD 4 Homicide determined Home Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the H only one) 29b. Signature 9d. Date signed (Month, Day, Year) 14 2010 and address of person who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day, Y State Registrar

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ore.	es 1 and 2 of Health a f item 27 is ir other trai		20a. Method of Disp	position			esition (Name of matory or other place)	Da		20c. Location - City o	
Baltimore,	permit. Pages. Department of Important: If ite any injury or of once.	- 3		□ Cremation 3 5 □ Other (Spe	Removal from State cify)	I	Mem. Gdns.	05/08/	2010 1	Fallston,	Maryland
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Σ	or Attendate after death	Certification:	4 Homicide	determine		ry - At home, farm, stre . (Specify)	eet, factory, office	28	f. Location (Str City or Town	eet and Number or F , State)	Rural Route Number,
	Io the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical C	29a. Certifier (Check only one)	1 Certifying I	Physician: To the best of aminer: On the basis of and manner sta	examination and/or in	n occurred at the time, ovestigation, in my opinion	date and place, an on, death occurred	d due to the call at the time, da	ause(s) and manner a ate and place, and du	as stated. e to the cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #30 per DVR 9903 5/7/10 TT State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 5 Day Physician/ Month Edward Frank Surlock 2010 4:00 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1405 Cranberry Rd Harford Aberdeen Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthdav If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Funeral** Days 1 🔀 M 2 🗆 F Months Hours |118–42–1332 59 Director Yrs New York Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director Maryland 28a-f Harford Aberdeen 1 ☐ Yes 2X No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? must be r Funeral |1405 Cranberry Rd 21001 USA within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates.1969–93 1 ☐ Yes 2X No Specify: SpecifyWhite "natural" Completed 3 Widowed 4 Divorced traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Serviceman US Military 12 Be permit. Page 1 and 2 should be file.
Department of Health and Mental Hv.
Important: If item 27 is marrany injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edward Joseph Surlock Alvira Carpentier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stacey M. Surlock / spouse 1405 Cranberry Rd, Aberdeen, MD 21001 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State West Chester, R.A. Ferris & Co. 5/8/2010 4 Donation 5 Other (Specify) Pennsylvania 21. Signature of uneral S 22. Name and Address of Facility
Tarring—Cargo Funeral Home, P.A.
333 S. Parke St. Aberdeen. MD 21001 23a. Part 1. Enter the e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death cercer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) use as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): the attending physician Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? for Month Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? certificate Yes 2 No 1 Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tyes Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) this 27. Menner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 66 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Venkata Krishna J. Parsa, MD 602 S. Atwood Rd. Suite 200 Bel Air, MD 21014 31. Date filed (Month, Day, Year) 32. Registar's Signature State Registrar

DHMH 17 Rev 7/2009

Box 68760

P.O.

BARBARA SNYDER

			1 - State C Registrar	of Maryland	_	artment of F <i>tificate of L</i>		ا Mental Hyو ا	giene _{Reg. No.} 2	010	14375
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المتحدية	Francis		5. Social Security Number 6. Sex	7. Age (In yrs. las	t hirthday)	Baltin If Under 1 Year		S. 8. Date of Birt	h	N/A	place (State on Favoier
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	s 23a or	Funeral Director	10e. Street and Number 2809 Cold Stream Way A	Apt. D		10f. Zip Code	1234		-	n of What Cou	ntry?
	r death or item iner m		Armed Fo	edent Ever in U.S. rces? 2 🔀 No	13. V If	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (i n, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14.	Race - Americ Black, White,	
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Baltimore, Maryland 21215-0036	be filed ental Hy 'ked oth ic event	To Be	17. Father's Name (First, Middle, Last) Robert	Snyder				ame (First, Middle, I		name)	<u> </u>
lary	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	- 2	19a. Informant's Name/Relationship (Type, Print)	vn, State, Zip (
e, ≥			Mark L. Stevens 20a. Method of Disposition	20h Pla		Cold Str	ream Way	Apt. D		more,	
timor			1 🔀 Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)	State cer	netery, crem	latory or other place. 1 Cemete		/05/2010		,	Maryland
Ball	permit Depart Impor any in		21. Signature of Funeral Service Licensee	lge	22.	Name and Addres	ss of Facility (hie High	Gonce Fun nway Bal	eral :	Service e, Mary	e, P.A. vland 21225
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P.O. Box 68	io tre nospital of Attending Priysician; The law requires that the death certifics within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as it.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Ves 2 Mo 9 Unknown Unknown Unknown 23c. If yes, outcome of pregnancy 23d. Date 23d. Date 23d. Date 3d. Date 23d. Date 3d.							ery Day Year	
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Division of Vital Records,	al or Atters as after de li Directo	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place buildir	of Injury - At home ng, etc. (Specify)	e, farm, stre	et, factory, office		28f. Location (St City or Town		ımber or Rural	Route Number,
_ : :	n 24 hour n 24 hour ne Funera oleted fill€	Medical	29a. Certifier 1 Certifying Physician: To the base only one) 3 Certifying Nurse Practioner: 1	s of examination a	nd/or investi	gation, in my opinio	 n. death occurred 	I at the time, date an	d place, and	d due to the car	use(s) and manner stated.
	Voithi Coa		29b. Signature and title of ceptifier M. M.			29c. License			9d. Date si	gned (Month, 1 2 3 / 20	Day, Year)
			30. Name and address of person who completed cause Mandi Yazdany - 56	al Lack	Ray	en Blv.	Balta	more, MI), 21	239	
	Stat Registra	e	31. Date filed (Month, Day, Year) 7 2010	egistrar s Signature	e A	Man V	,				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death **Physician** Day ROGER WAYNE SNYDER 3 2010 (538 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HARBOR HUSPITAL BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 06/27/1936 Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F 73 212 36 4376 Director Ohio Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shor Examiner must be notified at Director Maryland Anne Arundel Baltimore 1 ☐ Yes 2 TNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 336 Cresswell Road 21225 U.S.A. Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☑Yes 2 ☐ No 1956 If Yes, Give Year or Dates: 1962 Baltimore, Maryland 21215-0036 1 ☐ Never Married 2X Married "natural", or 1 □Yes 2**K** No Specify: à 3 ☐ Widowed 4 ☐ Divorced White Completed traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Item No Elementary/Secondary (0-12) 12th College (1-4or 5+) Brewery Bottler 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Snyder Belva Tennant မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grace Snyder / Wife 336 Cresswell Road Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State MD State Veteran Cem. 05/07/2010 Crownsville, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licenses 4001 Ritchie Highway Baltimore, Maryland 21225 23a, Part 1, Enter the disease shock, or heart failure. List or coordinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Examiner PNEUMONIA 10 DAYS Sequentially list conditions, if any, leading to immediate cause. For the cause Clases (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of): law requires that the death certificate be executed Exami and burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physiciar Physician/Medical the as use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ COPD 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Colon cancer 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an has director, page 2: autopsy performe Hospital or Attending Physician: The certificate 1 ☐ Yes 2 **☑** No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Medical Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

24 hours a within 2 To the

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

7ANG

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

FANO KU, MD

ORIGINAL

29c. License number

RES 001

HARBOR HOSPITAL,

29d. Date signed (Month, Day, Year) 5/3/10

> 21225 BALTIMORFHO

(S. HANGUER ST)

SHANOVERST,

3001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Harry H. Stroup Month Year 8:15a.M 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ealth Cerre System VA Merry land 5. Social Security Number (eci em Poin 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 217 20 3628 1 🛛 M 2 🗆 F Days Hours Min 83 West Virginia **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director N/A Maryland Baltimore 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Completed by Funeral 4212 Doris Avenue 21225 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
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X Yes 2 □ No Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Specify: 3 X Widowed 4 Divorced Year or Dates. WW II White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Mental Hygiene. Arundel Corporation Billing Supervisor Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry P. Stroup Ruby P. Bunner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health and tem 27 is n permit. Page 1 and 2 sl Department of Health a Important: If item 27 is Dale Smith 704 Deep Ridge Road BelAir, Maryland 21014 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park | 05/10/2010 | 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signatur of Fu eral Service Liv 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ ARGINOMA disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions If any leading to impect cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Month Day Year ed by the a detached f signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by USSTRUCTIVE LUNG 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPice 1 Yes 2. No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours Medical within 24 hor To the Funer completed fil 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 5/61 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maryland va Health Care System Perry Pointmodiso

State Registrar

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Name

32 / egistrar's Signature

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an: The law requires that the de ritificate has been signed by the tor, page 2 should be detached f	Completed by	25. Was case referred to medical		26.Place of Death (Check	autopsy performe 1 ✓ Yes 2	d? death?	ompletion of cause of								
ysician: The law requires that the de nis certificate has been signed by the director, page 2 should be detached f	Be Completed by	examiner? Hospital	1 Inpatient 2 ER/Outpa	Towns -	autopsy performe 1 Yes 2 only one)	d? death? No 1 ✓ Ye	ompletion of cause of								
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ing Physician: The law requires that the After this certificate has been signed by funeral director, page 2 should be detach.	To Be Completed by	examiner? 1 ✓ Yes 2 No Hospital 27. Manner of Death 28	T Inpatient 2 ENOutpa	e of Injury 28c. Injury at Work?	autopsy performe 1 Yes 2 only one)	d? death? 1 ✓ Ye sidence 6 ✓ Other:	ompletion of cause of								
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State 31. Date filed (Month, Day, Year) istrar XAY 0 7 2010 Registrar DHMH 17 Rev 1/2001 OCME 2006

State Registrar

within 2

29b. Signature and little of certifier

PAYAM MOHASSEL 31. Date filed (Month, Day, Year) Registrar's Signatu MAY 07 2010 men

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

parke

29c. License number

RES 000

29d. Date signed (Month, Day, Year)

5/1/10

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 05 2010 Simmons 12:50a.M Regina Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Future Care Nursing Home Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday. 8 Date of Birth Birthplace (State or Foreign Country) Funeral Months Hours 1 07 31 1 🗆 M 2 💢 F Director MD 219-28-3641 78 or 28a-f show 10b. County 10a. State other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 21206 **43**32 Sheldon Ave U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. ō ģ 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black "natural", Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 72 f Health and Mental Hygiene. item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) University Hospital 12th grade na Assistant Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Earl Thomas Regina Keys 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4332 Sheldon Ave, Baltimore, Md 21215 Simmons-Daughter Sherri 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arbutus Memorial Park 5/7/2010 Arbutus , Md 22 Name and Address of Facility
March F H West
4300 Wabash Ave, 21. Signature of Funeral Service Lid 21215 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate. Tuse (Final Baltimore , Immediate use (Final disease or condition resulting in death) Onset and Death Physician/ ementia Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine certificate be executed and -tran Due to (or as a consequence of) attending physician Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate Yes 2 No 1 Yes 2 No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending Natural work?
1 Yes 2 No 5 Pending injury within 24 hours after death.

To the Funeral Director: Al
completed filled in by the fu Investigation ☐ Accident ☐ Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 05,03,2010 30. Name and address of person who completed ause of death (Item 23a) (Type, Print) 2600 LIBERTY HAT ME, BATIMORE, MY SOSANYA m·D Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month MAY SARA ELIZABETH SPERLING 2010 5:55 P. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SPRINGWELL CENTER BALTIMORE CITY N/A Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F Months Days Hours Min. (Month, Day, Year) 8/11/1909 PĔŇŇŠYLVANIA **Director** 100 196-38-0199 cedent iral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No MD N/A BALTIMORE CITY 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2211 WEST ROGERS AVENUE 21209 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐XNo Specify. ¾ Widowed 4 □ Divorced Specify: WHITE Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 12TH GRADE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ JOHN SIMPSON MAZTE LIGHTCAP 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RONALD C. SPERLING/SON 1825 TRENLEIGH ROAD BALTIMORE, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) METRO CREMATORY, INC. 5/6/2010 | CATONSVILLE, MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. Sign turn of Funeral Service Ligensee MO1139 8521 LOCH RAVEN BLVD. TOWSON. 234 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician. The law requires that the death certificate be executed the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): Physician/Medical P.O. Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No cate has been signed by the atte page 2 should be detached for i Month Day Year 5 Other (specify) Pregnant at time of death Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 🗌 Yes To Be Division of Vital 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) ASSISTED IN IN 1 \square Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 🔲 Yes 2 🗌 No within 24 hours after death.

To the Funeral Director; A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a Certifier 1 Evertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

gistrar's Signature

N. Charles

TOW-SON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene 2 U | U State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Shic Kert Month 5 6 Day Physician/ Jayne 20 6 Year 1:05 AM Medical 4a. Facility Name (if not institution, give street and number) County of Death Examiner 4b. City, Town, or Location of Death Randallstown Baltimore Seasons Hospice at Northwest . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country)
 NIX **Funeral** (Month, Day, 1 □ M 2 □ XF Days 054-50-1802 55 1954 Director Nov Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Woodstock 1 🗆 Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21163 Funeral 10110 Old Court Road 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. þ 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) education school teacher Be 17. Father's Name (First, Middle, Last)
Howard Stone 18. Mother's Name (First, Middle, Maiden Surname) Doris (maiden name unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10110~01d~Court~Rd.,~Woodstock,~MD~21163Mr. Jessey Shickert (spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Lake View Memorial 1 X Burial 2 Cremation 3 Removal from State 5-11-10 Sykesville, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of FacilityHaight Funeral Home & Chapel Daige Staight Sterbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ Metastatic LUNG CANGER disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death Year 1 ☐ Yes 2 ₺ g ☐ Unknown been signed by the should be detached 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 bours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 completed filled in by the funeral director, page 2 completed. performed Yes 2 2 🗌 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ᇋ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manger of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier

MRajapamen D 29c. License number 29d. Date signed (Month, Day, Year) D0057465 5/6/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AV-S-235, Baltimore, MD-2/2D9. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2^{Day} Physician/ Month 2010° Phyllis Gayle Starr May 2:30 A^{M} Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 12020 Wetherfield Lane Potomac Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days April 28, 1951 Hours Min. 1 □ M 2 🗓 F Pennsylvania Director 187-42-0882 59 Usual Residence of Decedent 10a, State 10b. County within 72 hours after death with the Maryland items 23a or 28a-f sho ner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Pennsylvania Bucks Zionhill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18981 United States 522 West Cherry Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, ural", or iter I Examiner Armed Forces?

1 Yes 2 X No
If Yes, Give Black, White, etc. þ 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White "natural", Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pennsylvania Department of Elementary/Seconday (0-12) College (1-4 or 5+) the Agriculture t. Page 1 and 2 should be filed with thrent of Health and Mental Hygien rtant: If item 27 is marked other 1 ijury or other traumatic event, th Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Donald Clifford Starr Mary Rose Panak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12020 Wetherfield Lane, Potomac, Maryland, 20854 Dawn E. Starr / Sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Bate 5 20c. Location - City or Town, State 1 D Burial 2 X Cremation 3 D Removal from State permit. Page Department of Important: If any injury or 4 Donation 5 Other (Specify) 2010 Bethesda, Maryland Montgomery Crematorium, Inc. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, 7557 Wisconsin Avenue, Bethesda, Maryland, 20814-3501 ٤ M01596 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Onset and Death
10 Years shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Metastatic Breast Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Renal Failure 8 Weeks Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X 2 No 1 Tes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Sister's examiner? Other: 4 \square Nursing Home 5 \square Residence 6 X Other (Specify) Residence1 🗌 Yes 2 🛛 No 욘 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending _ .vatural

Accident 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) laine Benner K176874

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP.

32. Regis rar's Signature

Madelaine Binner,

31. Date filed (Month, Day, Year)

May 5, 2010

5505 Hopkins Bayview Circle, Baltimore, Maryland, 21224

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

AMEND TITEM# 2 per PHYS, G907, WS 28/2016, WS State of Maryland / Department of Health and Mental Hygiene? 14384 State Registrar Certificate of Death Reg. No. 2. Date of DeatiMay 4, 2010 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Day 010 Year Mary C. Todd М 6:15 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year) 1920 Maryland 1 M 2 218-03-0350 Director 89 June Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes XX No Maryland Harford Forest Hill 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 109 Forest Hill Drive 21050 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: giene. er than "natural", Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Hogarth Catherine Goedeke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Wawrzyniak / Daughter 38 Terrace Drive Northfield, Vermont 05663 injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) May 6, 2010 Holy Redeemer Cem. Baltimore, Maryland 21. Signatur / Funeral Se Vice Ligensee 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Service-Belair
3 Newport Drive Forest Hill, Maryland 21050 Maryland 21050 23a. Part 1. Enter the disease, or compositions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only / n / cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, DSIS disease or condition Medical resulting in death) Due to (or all a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death by not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 1 Yes 2 No 1 Yes 2 No • Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury 28b. Time of 28c ည 1 Yes 2 No 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of centifier Medicine ternal 29d. Date signed (Month, Day, Year) 266136 nenelle 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LIPPER CHESAPEAKE DR BEL AIR MO NNENNA 21014 UCHENDU 500 31. Date filed (Month, Day, Year) 32. Regist ar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 14385 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Edna Thornwell 11:20a^M 05 Medical 04 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Care Nursing Baltimore Future Home If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months Days 1 □ M 2√□ F Hours Min. Country) **Director** 83 20 51-16-6606 PA Usual Residence of Decedent 3a or 28a-f show t be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits 1 Yes 2 ☐ No MD Baltimore NA 10e. Street and Number 10g. Citizen of What Country? ms 23a omnust be 307 Millington Ave 21223 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. ŏ ş 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 1 ☐ Yes 2X No Specify. "natural", Completed If Yes, Give Specify: 3 - Widowed 4 X Divorced Black Year or Dates. er than "natur the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nd Mental Hygiene. marked other than matic event, the Mi Elementary/Seconday (0-12) College (1-4 or 5+) 10th grade Sewing Machine Operator <u>Joseph H. Coles</u> 1 and 2 should be filed w if Health and Mental Hygii item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Griffin Anna Lamar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tr <u>Theodore M. Peoples-Son</u> Millington Ave, Baltimore, Md 21223 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Mt. Zion 5/12/10 Donation 5 Other (Specify) Baltimore, Md 21. Sign tule of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave. Baltimore. Md 23a. Par 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each line. that h. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** al cers Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a 1 Yes 2 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 thinknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy death? 1 🗌 Yes 2 No Yes Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident☐ Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UBBROI

Registrar

State

31. Date filed (Month, Day, Year)

32. Reg

strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Was **Physician** 1:00 В. Tadlock /Medical Facility Name (If not institution, give street and number, 4b City Town or Location of Death County of Death Examiner Hmore TIMOre 5. Social Security Number If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1**X** M 2□ F Director 274-32-6711 6/28/1934 Texas Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Examiner must be notified at 1 ☐ Yes 2 ☐XNo Director Maryland Harford Edgewood 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 730 Sequoia Drive Funeral 21040 S. A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? 1XXYes 2 ☐ No Black, White, etc. 1XXYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 954 956 1 ☐ Yes 2 No Specify. þ Specify: 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Machinist Rubber Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Carter Tadlock Vera Maude Bullard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1150 Chesapeake Drive Havre de Grace, MD 21078 e of Disposition (Name of Date 20c. Location - City or Town, State Leah Schmidt (Daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Baltimore, Maryland Bayview Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue PA Essex, Maryland 21221 chael 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and ned for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear Day 5 Other (specify) P.O. 9 ☐ Unknown 9 Unknown signed by t t be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an director, page 2 autopsy demento Vital 1 □Yes 2 12 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To ð this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Division **Hospital or Attending** 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No n 24 hours after death.

Pe Funeral Director; A

oletely filled in by the fi investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifyling Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Cynthia Sman hos 10051347 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CYNTHIA SOLIND MS 6701 N. Chorles ST Baltimore MD 2120 Y CYNTHIA

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** May 2,2010 2218P Alvin Lennan Vogtman /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Upper Chesapeake
5. Social Security Number 6. S Harford Bel Air nder 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
March 3,1924 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days 1**X** M 2□ F Months Hours Min. Maryland 218-14-4725 86 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 □Yes 🛣 □ No **Funeral Director** Forest Hill Harford Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21050 USA 2913 Smithson Dr. 12. Was Decedent Ever in U.S. Armed Forces? 1. Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, 11. Marital Status Black, White, etc. 1 ∏Yes 2 □ No If Mes, Give Year or Dates: 1944-1946 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced White 1 ☐ Yes 2 No Specify: Completed by Specify: 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Printer Lithograph Printing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edith Boring William Vogtman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2913 Smithson Dr. Forest Hill, Md. Alice M. Vogtman Spouse 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) M Burial 2 ☐ Cremation 3 Removal from State Gardens of Faith 5-6-2010 Balto.Md. 21206 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home 21. Signature of Funeral 9705 Belair Rd. Nottingham, Md. 21236 Pirt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due lo (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregna in the past 12 months 3 Ectopic pregnancy Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □ Yes 2 **1**No 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Physician: The law requires that the death certificate be executed Octimon Hospital or Attending

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show

permit. Pages 1
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Important: If ite
any injury or ot

Physician

/ /Medical

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Director:

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Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, if a liverifical Evaminar must be notified at

State DHMH 17 Rev 1/2001

Registrar

(Check only one)

Herri

29b. Signature and title of cartifier

31. Date filed (Month Day, Year)

Registrar's Signatur

and manner stated.

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30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

ORIGINAL

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 3 per dr.,g903,05/07/2010dhb Reg.No. For State Registrar 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month 12:20a M **Physician** be Sa nel 2011 /Medical 4b. City, Town, Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Severna Park Anne Arundel Genesis Severna Park 8. Date of Birth (Month, Day, Jan 21, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) if Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** ^{Year)} 1921 1 □ M 2 🛛 F Months Days Hours Min. West Virginia Director 234-34-4096 89 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiens. Internet of Health and Mental Hygiens in Figure 1, it fem 7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Medical Examinational traincillied at MD Prince Georges Bowie Director 1 ☐Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14497 Health Center Drive 20716 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 ∏Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No white Specify þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) housewife own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Earl Benton Powers Esta Linville ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane Shoemaker/daughter 1912 Carriage Knoll Dr; Bethlehem, PA 18015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4⊠Donation 5 Other (Specify) 21. Sigvatur of Funeral Service Licensee Wade State Anatomy Board; 655 W. Baltimore Street Baltimore, Maryland 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia Cause (Final disease or dition resulting in death) Physician cer ebrovas minites /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Lue to (or as a consequence of): Examiner law requires that the death certificate be executed and Due to (or as a consequence of) burial attending physician for use as the burial Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregrant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Year 5 ☐ Other (specify) P.O. sed by the adetached 1 9 Unknown 9 ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 licate has been się r, page 2 should b CONE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Completed Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No was a autopsy performed? 24a, Was an To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h completely filled in by the funeral director, page 1 ∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 4-22-2010

State Registrar 31. Date filed (Month, Day,

Name and address of person who completed cause of death (Item 23a) (Type

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day 2010 ear Physician/ May Martin R. Windisch Jr. 7:35p M 3 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Gilchrist Center Baltimore Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral 1 🕱 M 2 🗆 F Hours Min. Jan 19 220-12-8082 **Director** 83 Usual Residence of Decedent items 23a or 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland **Funeral Director** MD Baltimore Baltimore 1 🗌 Yes 2 🗶 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5201 Kenwood Avenue 21206 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or Completed by 1 Never Married 2 X Married ∑Xyes 2 □ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Custodian Baltimore Co, 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) if Health and Mental I Martin Windisch Matilda Rohe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Windisch /son 922 Woodlynn Road Baltimore_MD_212<u>21</u> 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it 1 Burial 2 Cremation 3 Removal from State Bayview Crematory injury or 5/7/10 Balto. MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each kine. Approximate Interval Between shock, or heart failure. List only one cause on each Immediate Cause (Final Onset and Death Physician/ rome disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 Ectopic pregna 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown Part-II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autops, performed? death? 2 No 1 Yes å 25. Was case referred to medica 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 욘 4 Nursing Home 5 Residence 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Deal 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 🗌 Yes 2 🗀 No Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifie License number 29d. Date signed (Month, Day, Year) 2010

Registrar DHMH 17 Rev 7/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1- State Amend Items 27,28a-1	per me,	Certificate of Death		3. No.	14390
Physic	ian	1. Decedent's Name (First, Middle, Last)	(, '	lillians	2. Date of Death Month	Day Year	3. Time of Death
/Medi	cal	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Dea		4c. County of Death	8.301 "
Exami	ner	Tokas Hoking Bayueu	· .	3 Salprore		Baltino	92.
Funeral	_	5. Social Security Number 6. Sex 7. Ac	ge (In yrs. last birt	hday) If Under 1 Year If Under 24 Hi			place (State or Foreign
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with the Maryland a or 28a-f show be retified at	Director	MD NA 10e. Street and Number	Ва	ltimore 10f. Zip Code	100	g. Citizen of What Cou	
with	Ö						,,
death wi	Funeral	3308 Lawnview Ave	Ever in U.S.	21213 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No-	U.S.A. 14. Race - Ameri	
rmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland partment of Health and Mental Hygiene. portant: If item 27 is marked other than "natural", or items 23a or 28a-f show y Injury or other traumatic event, the Medical Examined requirements at the multiple at Examined 1.		Armed Forces? 1 Never Married 2 Married 1 Yes, Give Year or Dates:	No	If Yes, specify Cuban, Mexican, Pue 1 □ Yes 2 □ No Specify:	erto Rican, etc.)	Specify: B1	
"natura	Completed by	15. Decedent's Education	16a.	Decedent's Usual Occupation	orking 16	6b. Kind of Business/In	
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d wit	5	12th grade 8yrs	Ea	rly Childhood Te		ublic Sc	hools
tal Hy d oth	Be (17. Father's Name (First, Middle, Last)		18. Mother's N	ame (First, Middle, Ma	aiden Surname)	
should be and Mental s marked o	ုင	Nathaniel Melvin			e Harold		
nd 2 should be filed within alth and Mental Hygiene. 27 is marked other than "r traumatic event, i'r Me		19a. Informant's Name/Relationship (Type. Print)	i	Mailing Address (Street and Number or I			
s 1 and 2 of Health item 27 i		Guana Williams-Daughter 20a. Method of Disposition	20h Place of	36 Ricks Way Roa	d, Pikes	sville, M	d 21208 own. State
Pages nent of lint: If its		1 Burial 2 ☐ Cremation 3 ☐ Removal from State		Disposition (Name of y, crematory or other place)			,
it. Pe intme intant injury		4 □ Donation 5 □ Other (Specify)	King	Memorial Park 3	/19/10 W	Woodlawn,	Ma
permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		21. Signature of Funeral Service Licensee	<u></u>	22. Name and Address of Facility March F/H West 4300 Wabash Ave	e, Baltim	nore, Md	21215
		23a. Part . Enter the disease, or complications that cause shock, or heart failure. List only one cause on each li	the death. Do n ne.	not enter the mode of dying, such as card	ac or respiratory arres	st,	Approximate Interval Between Onset and Death
Physician	ı	Immediate Cause (Final disease or condition	Seas	5			1060KZ
/Medical Examiner		resulting in death) Due to (or as	a consequence of	of):	¥ 4		
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ted	Examiner	Sequentially list conditions, if any leading to him solate cause. Enter Underlying Cause (Disease or injury	o nomenumento e		1. \ - \ -		055
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t the by th ache	hys	9 Unknown					
Physician: The law requires that the death cert this certificate has been signed by the attendin rat director, page 2 should be detached for use a		Part II. Other significant conditions contributing to death t	out not resulting in	the underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
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he law require e has been si tge 2 should t	plet	Sacrat wound wi	it or	termielits.	24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
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rding Physician: Th. th. : After this certificate funeral director, pag	Be	25. Was case referred to medical examiner?		26. Place of D	eath (Check only one)		
il or Attending Physician: 1 after death. Director: After this certifica d in by the funeral director, p	은				Home 5 ☐ Residen	nce 6 Other (Spec	ify)
re fe	Ë	27. Manner of Death 28a. Date of Inj → Thatural 5 □ Pending July 100 200		Time of 28c. Injury at Work?	28d. Describe how	vinjury occurred Fell & ston	ach perfo
Attending r death. ector: After by the fune	cati	2 Accident investigation August	2008 Unki	nown M 1 □ Yes 2♣ No		ell & ston ring gastr	
or At fiter of Direct in by	Certification:	4 Homicide determined 28e. Place of In building, e	ury - At home, far c. (Specify)	rm, street, factory, office	281. Location (Stre City or Town,	el and Number or Rui State) 3308 La Md & 4940	wnview Av
pital urs a eral [, death occurred at the time, date and pla	Baltimore	e,Md & 4940	Balto.
To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner si	Ji examination an	d/or investigation, in my opinion, death of	curred at the time, dat	te and place, and due	to the cause(s)
To th within To th	Me	29b. Signature and title of certifier		29c. License number		d. Date signed (Month	
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(6)		30. Name and address of person who completed cause of	TER His	Type, Print) 5505 Hop D Balt MS		y Vian Ci	
Str	ate	31. Date filed (Month, Day, Year) 32. Regist	rar's Signature	1. Sare		•	
Regist		WAY 0.7 2010 ►2	soin &	1. Barrel			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 per me, g903,05/07/2010dhb Certificate of Death Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Ry WM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Oct. 29, 1914 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗷 F Virginia Director 215-32-8517 Usual Residence of Decedent 10d. Inside City Limits 10b Count 10c. City, Town or Location 10a State 28a-f show traumatic event, the Medical Examiner must be notified at 1 □Yes 2 →No Director Pasadena Anne Arundel Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò U.S.A. 23a 320 Brookfield Road 21122 Funeral items ? 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∏Yes 2X If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married 2**X** No Baltimore, Maryland 21215-0036 1 □Yes 2 🛣No ò Specify: þ White 3 ₩ Widowed 4 Divorced 'naturai" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Hospital 12 Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be f Stoneman Annie ပ Fred Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10134 Green Clover Drive Ellicott City, MD 21042 permit. Pages 1 and 2 Department of Health a Important; If item 27 is any injury or other tra William Donald Wirth (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition tX Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Burnie, Maryland 04/30/2010 Glen Haven Mem. Pk. 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee ^{22. Name and Address of Facility} McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 Approximate Interval Between Onset and Death 23a. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 0 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner CERTIFICATION APPROAGO BY MEDICAL EXAMINER Physician: The law requires that the death certificate be executed physician and the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.0. s been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2/ No 3 Probably 4 Unknown 1 🗆 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has e 2 s autopsy perform page certificate 1 ☐Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) director Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA this Certification: To funeral 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the pass of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b Signature and title of certifi 29c. License number completed as se of death (Item 23a) (Type, Print) and address of n 32. Aegistrar's Signature Date filed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

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Maryland 21215-0036	be filed ental Hyg ked oth ic event	To Be	17. Father's Name (First, Middle, I Thomas Edward	•				18. Mother's Name (First, Middle, Maiden Surname) Dorothy Waters								
aryl	should be fill and Mental is marked of raumatic eve		19a. Informant's Name/Relationship (<i>Type, Print</i>) Chloe Winn/niece 19b. Mailing Address (Street 29512 Hemlock)							Number or Rural Route Number, City or Town, State, Zip Code)					-	
Σ	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hiury or other traumatic event, the Medical Examiner must be notified at one.								Lane	; Ea	ston, l	Mary.	land :	2160	1	
Baltimore,			20a. Method of Disposition 1 Burial 2 Cremation 4X Donation 5 Other (5			ace of Dispos metery, crem			e)	[Date	20c. L	ocation - C	ity or To	wn, State	
Balti	permit. F Departm Importa any inju once.	Í	21. Signature Funeral Service Licensee State Anatomy Board; 655 W. Baltimore Board; 655 W. Baltimore Board; 655 W. Baltimore Board; 655 W. Baltimore Board; 655 W. Baltimore Board; 655									Street				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ May 6:45 A Medical Jeanne R. Williams 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Citizens Care & Rehabilitation Center Harford Havre de Grace 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year Nov. 24, 19 9. Birthplace (State or Foreign Funeral 1 □ M 2 🔀 F Months Days Hours Min. Director 086-26-3593 New Yor Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director Harford 1 Yes 2 No Maryland Bel Air 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 713 Reedy Circle 21014 United States should be filed within 72 hours after death and Mental Hygiene.

is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces þ 1 Never Married 2 Married Yes 2 XNo Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Shop Keeper Country Gift Shop Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic injury or other traumatic Earl Harvey Rightmyer Rosalind Rislev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond Williams (Husband) Bel Air, Maryland 21014 713 Reedy Circle Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Har Toro Mellor Ial 4 Donation 5 ☐ Other (Specify) May 11, 2010 Aldino, Maryland 22. Name and Address of Facility

Evans Funeral Chapel & Cremation Services—Bel Air

3 Newport Drive Forest Hill, Maryland 21050 21. Signature of Funeral Service Licensee Part 1. Ent at the disease or complications that caus shock, or heart ailure. Let only one cause on each li 23a. Part 1. Ent or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be execute use as the burial-tran cate has been signed by the attending physician and page 2 should be detached for use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box (3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably certificate has been 24a. Was an Were autopsy findings available prior to completion of cause of autopsy perform death? 2 🖪 No 1 🗌 Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) after death.

Director: After this 27. Manuar of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work? 1 Yes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 29b. Signature and title of certifier

of person who completed cause of death (Item 23a) (T

Registrar's Signature

4

6/14

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MYNN Month JAMES 5.15 PM 0/0 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Columbia Howard Five Fingers Way Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Country)
Virginia Months Days Hours Min (Month, Day, Year) Director 87 230-18-6117 Jul 02 Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director ed other than "natural", or items 23a or 28a-f slevent, the Medical Examiner must be notified 1 Yes 2 No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6555 Booker Ave 21060 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 □ Divorced Specify. WWI Year or Dates. Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 6 Bethlehem Steel Steel Worker Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lullyn Wynn Carrie Macklin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Riley Wynn /Son 6555 Booker Ave. Glen Burnie, MD 21060 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State May 1 4 Donation 5 Other (Specify) Cemeter 2010 Crownsville, Maryland Crownsville Vet. 21. Signature of Funeral Service License 22. Name and Address of Facility
Funeral Alternatives Rebecco Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ lenolle disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine attending physician and for use as the burial-transit home that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 2 🗌 No Yes Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 \(\subseteq \text{ Nursing Home } 5 \subseteq \text{Residence } 6 \subseteq \text{Other (Specify)} 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 IDOA After this funeral 28a. Date of injury (Month, Day, Year) 1 Natural Manner of Death 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Investigation Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined edical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Descripting Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the F only one) 29b. Signature and title of certifier May 3, 2010 D30641 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road Baltimore Maylad 2122 River MICK Sabapathi 201-109

State Registrar DHMH 17 Rev 7/2009 31. Date filed (Month, Day, Year)

32 Registrar's Signature

Back

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $M_{ay}^{Month}4$, 20^{10} Physician/ Richard Patrick Wynne 9:15 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 443 West Diamond Avenue #301 Gaithersburg Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours May 23, 1957 1 🕅 M 2 🗆 F Rhode Island 52 Director 212-76-9095 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Montgomery Gaithersburg 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 443 West Diamond Avenue #301 20877 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Never Worked None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Donald M. Wynne Helen Harding .. Page 1 and 2 should tment of Health and M tant: If item 27 is mai 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen H. Wynne/Mother 8607 Postoak Road, Potomac, Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Removal from State Montgomery Creamatorium, 4 ☐ Donation 5 ☐ Other (Specify) Inc. May 7, 2010 Bethesda, Maryland 21. Signature of Funeral Service Licenaes Page 1 And Address of Facility Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850 Haron Mou M01530 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death ₽nysician, rentenian disease or condition resulting in death) Medical Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transi the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Year signed by the a 1 Yes 2 L Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 No death? certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical B 26. Place of Death (Check only one) examiner? 1 🖾 Yes 2 🗆 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 잍 1 Inpatient 2 ER/Outpatient 3 DOA this After this funeral of 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be illed in by the f Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State 24 hours Medical 1 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) or frende Nome 5-5-2010

State Registrar

DHMH 17 Rev 7/2009

32. Registra 's Signature

200 Gerard Street, Gaithersburg, Maryland 20877

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Parvej Malik, M.D.

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2, Physician/ Year 201°0 May 4:50 Velva Ann Willis РМ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Funeral Days July 18 Hours Min. 1921 West Virginia Yrs 215-74-8969 Director 88 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 414 Denham Road 20851 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Completed 3 X Widowed 4 Divorced Specify. White permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James Robinson Florence Gill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie E. Willis/Daughter 414 Denham Road, Rockville, Maryland 20851 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) May 6.20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Montgomery Crematorium, Inc. Bethesda, Maryland 21. Signature of Funeral Service Ligensee Robert A. Pumphrey Funeral Home/Rockville, Inc. M01360 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause /Final Hours Physician/ Acute Anterior Wall Myocardial Infarction disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Six association liet exactly are Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or linjury and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a I be detached f þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed' certificate 2 No Yes 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 💢 No 1 Tyes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: To After this 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work within 24 hours after death. To the Funeral Director: A Investigation
6 Could not be 1 Yes 2 No Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 2 [3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D42110 2,2010 MI

State Registrar

DHMH 17 Rev 7/2009

15225 SHARM

GROVE RO. POOPVILLE

MARYLAND 20850

dress of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Regist ar's Signature

D. C. GRI HE

31. Date filed (Month. Day. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 1-Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 8:17PM -ayed 5 2010 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State of Country) Days Hours 1 M 2 F Yrs none United Arab 10 Dec 02, 1999 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Md. Baltimore 1 X Yes 2 No **Funeral Director** 10e. Street and Number 10g. Citizen of What Country? 10f. Zip-Code United Arab Emirates 218 N. Charles St. #1204 21201 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2★ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Arabic 1X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) None None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Saif Al Harbi Seham Hazaa Al Harbi ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 218 N. Charles St. #1204, Baltimore, Maryland 21201 Saif Al Harbi 20b. Place of Disposition (Name of cemetery, crematory or other place) Family Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4-20-2010 United Arab Emirates 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityUniversal Mortuary Inc. 411 Kennedy St, N.W., Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each Immediate Cause (Final ungal disease or condition resulting in death) Due to (or as a consequence of):

Physician /Medical **Examiner**

Funeral

Director

28a-f show must be notified at

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Health and Mental Hygiene.

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Department of H Important: If ite any injury or otl once.

Baltimore, Maryland 21215-0036

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Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Date to (or as a consec	Myeloger	nors Leuke	ma	
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Part II. Other significant conditions of	ontributing to death but not re	sulting in the underlyin	ng cause given i <i>n</i> Part I.		to use contribute to the cause of death? 2 PNo 3 Probably 4 Unknown
				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? No 1 □ Yes 2 □ No
25. Was case referred to medical examiner?	Hoopitali			eath (Check only one)	
1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 Residence	
27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	ljury occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At h building, etc. (Specia		ory, office	28f. Location (Street Cify or Town, Sta	and Number or Rural Route Number, te)
	ysician: To the best of my knowniner: On the basis of examination and manner stated.				e(s) and manner as stated. and place, and due to the cause(s)

29c. License number

D0067376

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

State Registrar

Ze

Michael 31. Date filed (Month, Day, Year) APR 1 8 2010

29b. Signature and title of certifier

32. Regis

red (. Melmy

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

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	s 23a	era	11302 Old Mar	lboroPike			20772				U.	S.A.			
	death item ner n	Fur	11. Marital Status	12. Was Decedent Eve Armed Forces?		13. Was	Decedent of Hes, specify Cuba	ispanic Ori an, Mexicar	gin? (Specify n, Puerto Ric	Yes or No- an, etc.)		14. Race - A Black, N			
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9	atura cal E	ete	15. Decedent's		16		t's Usual Occup				16b.	Kind of Busin			1
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Division of Vital Records, P.O. Box 68760	the d by the tacher	hys	g 🗌 Unknown	g 🗌 Unknown											_
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	To the within To the company	2	29b. Signature and title of certifier		or or my kill	ago, acc	29c. Licens	e number		340 10 11		Date signed (A			_
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	.2		30. Name and address of person wh	o completed cause of dea	th (Item 23a) (Type, Prir	t) /		٠ ٠٠٠	2 0	, 1 ^				
A			JK Brian Bayly	7 223 H on	DIPC !	rorkw	oy bro	ecnyel	T INV	, 207	10				_
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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			Cremation 3		from State	C	emetery, crem	sition (Name of eatory or other pla	· · ·		Date		ocation - City			
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Hospita 24 hours Funeral eted filler	Medical	(Check 2	☐ Medical Exa	miner: On the	basis of ex	xamination	and/or investi	ocured at the time	on, death	occurred at	the time, date a	and place,	and due to t	the cause		tated.
To the within To the comple	Σ	only one) 3 29b. Signature and t		urse Praction	ner: lo the	best of my	knowleage, a	eath occurred at the 29c. Licens	e number		e, and due to th		e signed (M			
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April Roberta I. Byers 2010 1:20A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington Williamsport Williamsport Nursing Home 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 232-01-8682 Director 93 **1**917 West Virgini Jsual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Williamsport Washington MD ¥X Yes 2 □ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21795 USA 154 N. Artizan St. 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2√3 No Black, White, etc 1 X Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white If Yes, Give "natural", 3 Widowed 4 Divorced Specify: Completed Year or Dates other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) if Health and Mental Hygiene. Item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) administration rock quarry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Elmer Byers Isadora Bowers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Benjamin F. Byers/brother 2538 Greensburg Rd. Martinsburg, WV 25404 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State rmit. Page 1 a partment of P portant: If its Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
Rosedale Cemetery injury or 4/30/2010 Martinsburg, WV 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Rosedale Funeral 22. Name and Address of Facility any Der 917 Cemetery Rd. Martinsburg, WV 25404 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Kinjons Medical Due to or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Day Year ed by the a detached f 2 No 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed' death? 2 No Yes 2 N To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death. To the Funeral Director: After this 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury Natural 5 Pending Accident 1 Tes 2 No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and affle of certifier 29c, License number 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WH: 3 Shahid mahmood m1) 580 C Northern Hagerstown APR 28 31. Date filed (Month) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Division or Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

101

29b. Signature and title of certifier

E. LATTIN.

32. Registrar's Signature

COLUDIAL

29c. License number

0005835

way, Rising Sun, M.D. 21911

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2 | | | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ IZABETH 04 Medical 4a. Facility Name (if not institution, give street and number 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Mandrin Hospice House Anne Arundel Harwood Social Security Numbe 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 🗆 M 2 💢 Days Hours Min. 319-40-6216 6/26/1948 63 Iffinois Director Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at 10a State Maryland Anne Arundel 10d. Inside City Limits 10c. City, Town or Location Director Annapolis 1X☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21401 USA Funeral 51 East Street 12. Was Decedent Ever in U.S. Armed Forces 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. White þ 1 Never Married 2 Married 1 Yes filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 X Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natur.
any injury or other traumatic event, the Medical coce. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) College Professor Education Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Edward Frederick Blettner Margaret Maw 19a. Informant's Name/Relationship (Type, Print)
Jean B. Angell - Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 Central Park West, New York, NY 10023 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Atlantic Crematory 4/21/2010 Glen Burnie, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examir attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Dav Year Pregnant at time of death ned by the a 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been signe should be o 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed? Yes 2.V No 2 🗆 No 1 Tes Hospital or Attending Physician: ours after death.

neral Director: After this certific filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 I 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Matural 2 Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. сотрыете 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the P within 2 To the P only one) 29b. Signatur and title of certifie NH Name and address of person who completed cause of death (Item 23a) (Type, Print) State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 2 per doc 9903 5-11-10 yt.
State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 22 3. Time of Death Physician/ Month 04 2010 Meredith Esther Brown 8:00 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 □ M 2 🏻 F Months Days Hours Min. 05 1 T Year) 910 Director 579-90-3202 99 Nebraska Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Ty Yes 2 No Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1235 Potomac Valley Road 20850 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No
If Yes, Give Black, White, etc. 1 \square Never Married 2 \square Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Milton D. Livington Elsie Bell Buster 1 and 2 should be Health and Mei 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barton L. Brown, Sr./ Son 10-A Tranquility Trail Hopewell Junction, NY 12533 injury or other 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 and Department of Filmportant: If ite Date 20c. Location - City or Town, State Ft. Lincoln Cemetery | 05 08 2010 Brentwood, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Ft. Lincoln Funeral Home any 3401 Bladensburg Road Brentwwod, MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Pneumonia disease or condition 6 days Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Other (specify) Month Dav Year 4 ☐ Pregnant a 9 ☐ Unknown the 9 Unknown þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dementia Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【 Unknown page 2 should certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2X N 2 🗌 No 1 Yes Yes 25. Was case referred to medical examiner? within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🛣 No Other: မ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 🔀 Natural 5 Pendina 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D38262 April 22, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 Research Blvd. Suite 330 Rockville, MD Anurita Mendhiratta

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

APR 2 7 2010

32. Registrar Signatu

DOB; 10/26/33 DOD; 4/19/10 TDD; 13:30 Baltimore, Maryland 21215-0036 Barr, Mollic A. SS# 079-26-2304 Division of Vital Records, P.O. Box 68760,

	for State Registrar	Olate of Wi	aryland / D	Certificate			ieniai ny	/gienę Reg. No.	211111	14405
ian	1. Decedent's Name (First, Middi						2. Date of Do			3. Time of Death
ical	Mollie	A Ba	1				04	19	2010	1420 M
iner	4a. Facility Name (If not institutio	n, give street and number)	t-1		own, or Location	on of Death		4c.	County of Death	
	5. Social Security Number	6. Sex 7. Ag	e (In yrs. last birth	day) If Under 1		der 24 Hrs.	8. Date of Bi	rth av. Year)	9. Birth	place (State or Foreign
	079–26–2304 Usual Residence of Decedent	1 L M 2 X F	76 Y	rs.			10/26	/1933	3	New York
_	10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
Director	MD Worce	ster		Ocean C	ity					1 □Yes 🎎 No
	10e. Street and Number	W40.4		10f. Zip C				10g. Citi	zen of What Cou	ntry?
Funeral	301 Boardwalk	12. Was Decedent I	Ever in U.S.	13. Was Deceder	21842 nt of Hispanic	Origin? (Sp.	ecify Yes or No	0-	USA 14. Race - Ameri	can Indian.
	1 ☐ Never Married 2 🔀 Married	If Yes Give	Мо	If Yes, specify	Cuban, Mexi	can, Puerto	Rican, etc.)		Black, White,	
ag D	3 Widowed 4 Divorced	Year or Dates:	40						Specify:	White
plet	(Specify only highe	it's Education st grade completed)	(Decedent's Usual (Give kind of work life. DO NOT use	done during m	ost of worki	ng	16b. Kir	nd of Business/Ir	dustry
Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	Homema	aker				Own Home	9
ů n	17. Father's Name (First, Middle,	•			18. Mo	ther's Name	(First, Middle	, Maiden	Surname)	
٩	Jack Friedman 19a. Informant's Name/Relations		10h J	Mailing Address (5			Israel	City or	Town Chair 7	- 0-4-)
	John A. Barr/H	, , , ,		01 Board						,
	20a. Method of Disposition 1 XBurial 2 ☐ Cremation		20b. Place of D	Disposition (Name crematory or other	of		ate		cation - City or To	
	4 □ Donation 5 □ Other (S	pecify)	Sunset	Memoria	l Park	04/22	/2010	Ber	lin, Mar	cyland
	21. Signature of Funeral Service	Licensee		22. Name and	Address of Fac	^{ility} Bea	ll Fune	eral	Home	
	23a Par 1. Ent The disease, or	complications that caused	the death. Do no	t enter the mode of	W Crain of dying, such	1 Hwy. as cardiac d	, Bowie	∋, MD ırrest.	20715	Approximate
	hock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on each lin	e. RD				, ,	,		Interval Between Onset and Death
	resulting in death)	Due to (or as a	a consequence of	1						
,	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	a consequence of)							
Examiner	cause. Enter Underlying Cause Unsease or injury that initiated events	Due to (of as a	consequence or							
	resulting in death) Last	Due to (or as a	a consequence of)	•						
Physician/Medical		d								
S	IF FEMALE:	23c. If yes, outcome	of pregnancy							
Cla	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No	1 Live birth 4 Pregnant at	2 🗌 Fetal death	3 ☐ Ectopic preg 5 ☐ Other (spec				2	3d. Date of deliv Month	ery Day Year
,uys	9 ☐ Unknown	9 🗆 Unknown								
Š	Part II. Other significant condition		t not resulting in th	ne underlying caus	se given in Par	t I.				he cause of death?
מונים		, 14(00,	7.00(2)	-			<u> </u>		4 No 3 ∐ Prol	oably 4 Unknown
~							24a. Was autoj perfo		24b. Were auto prior to co death?	psy findings available mpletion of cause of
E										2 □ No
	25. Was case referred to medical				26 Pla	ce of Death	1 ☐ Yes			
Ř	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	nt 2 ER/Outp	atient 3 DOA	Oaleani		(Check only o	ne)	☐Other (Special	·y)
o Re	examiner? 1 Yes 2 No 27. Manner of Death Natural 5 Pending	28a. Date of Injur (Month, Day	y 28b. Tin	ne of 28c.	Other: 4 Injury at Work?	Nursing Hor	(Check only o	<i>ne)</i> dence 6		(y)
0 20	examiner? 1	28a. Date of Injur (Month, Day)	y 28b. Tin Year) Inju	ne of 28c.	Other: 4 Injury at Work? 1 Yes 2	Nursing Hor	(Check only one 5 ☐ Resident	dence 6	occurred	
0 26	examiner? 1	28a. Date of Injur (Month, Day)	y 28b. Tin (Year) 28b. Tin Inju	ne of 28c.	Other: 4 Injury at Work? 1 Yes 2	Nursing Hor	(Check only one 5 ☐ Resident	dence 6 how injury		
Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death Solvatural 5 Pending	28a. Date of Injur (Month, Day) ation not be ined 28e. Place of Injur building, etc. g Physician: To the basis of Examiner: On the basis of	y 28b. Tin Year) 28b. Tin Inju ry - At home, farm (Specify) f my knowledge, of examination and/	ne of 28c. M , street, factory, of	Other: 4 Injury at Work? 1 Yes 2 Iffice	Nursing Hor	(Check only of the State of the	dence 6 how injury Street and wn, State)	Number or Rura	al Route Number,
edical Certification	examiner? 1 Yes 2 No 27. Manner of Death No Natural 5 Pending 2 Accident investig 3 Suicide 6 Could n 4 Homicide determi	28a. Date of Injur lation not be ined 28e. Place of Injur building, etc.	y 28b. Tin Year) 28b. Tin Inju ry - At home, farm (Specify) f my knowledge, of examination and/	ne of Iry M 28c. M, street, factory, of death occurred at 1 or investigation, in	Other: 4 Injury at Work? 1 Yes 2 fice the time, date my opinion, d	Nursing Hor	(Check only of the State of the	dence 6 how injury Street and wn, State) cause(s) date and	occurred Number or Rura and manner as s place, and due to	of Route Number, stated. the cause(s)
edical Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death Solvatural 5 Pending investig 3 Suicide 6 Could n determi 29a. Certifier (Check only one) 1 Certifyin 2 Medical i	28a. Date of Injur (Month, Day) ation not be ined 28e. Place of Injur building, etc. g Physician: To the basis of Examiner: On the basis of	y 28b. Tin Year) 28b. Tin Inju ry - At home, farm (Specify) f my knowledge, of examination and/	ne of Iry M 28c. M street, factory, of death occurred at 1 or investigation, in 29c. Li	Other: 4 Injury at Work? 1 Yes 2 Injury at Work? the time, date my opinion, dicense number	Nursing Hor	(Check only of the State of the	dence 6 how injury Street and wn, State) cause(s) date and	and manner as splace, and due to e signed (Month,	of Route Number, stated. o the cause(s) Day, Year)
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DHMH 17 Rev 1/2001

Director

Be Completed by Funeral

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Examine

Physician/Medical

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Be Completed

Medical Certification: To

Physician

/Medical

Examiner

Please	Type or Print in E amend item II State of Marylan	Black lu per f	ndelible in	k. Ensure /	All Copies /	Are Legible.	
1 - For State Registrar	State of Ivial yla	Ce	ertificate of	f Death		eg. No. 2010	0 14405
1. Decedent's Name (First, Middle, Last	t)				2. Date of Death	h	3. Time of Death
	lbourne				April 3	21,2010	0 5:25 PM
4a. Facility Name (If not institution, give MANOKIN 5. Social Security Number 6. Se	NOR	1-at hirthda	PRINC	or Location of Death LESS ANI ar 1 If Under 24 Hrs.	NE	4c. County of Deal	rset
	Пм 2127 г	86 Yrs.	Months Days			Year) Co	rthplace (State or Foreign country) irginia
10a. State 10b. County VA Accomack		ty, Town or L Atlant					10d. Inside City Limits 1 □Yes 2 No
10e. Street and Number		ALLLI	10f. Zip Code	,	1C	Dg. Citizen of What Co	ountry?
10018 Atlantic Roa			23303			USA	
11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Tes 25 No If Yes, Give Year or Dates:	S. 13.	3. Was Decedent of If Yes, specify Cul	f Hispanic Origin? (Suban, Mexican, Puert o <i>Specify</i> :	pecify Yes or No- to Rican, etc.)	14. Race - Ame Black, White	
15. Decedent's Edu	ucation		cedent's Usual Occu		1	16b. Kind of Business/	
(Specify only highest grade Elementary/Secondary (0-12) 8	de completed) College (1-4or 5+)	(Give	ve kind of work done . DO NOT use retire .	ne durina most of wor	rking	Healthcare	
17. Father's Name (First, Middle, Last)				18. Mother's Nan	me (First, Middle, Ma		
Harry Thomas				Elsie Th			
19a. Informant's Name/Relationship (Ty	. ,					City or Town, State, 2	Zip Code)
Sheila Coulbourne 20a. Method of Disposition 1 🗷 Burlal 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	Removal from State 20b. Pl	Place of Disponentery, creation	Box 794 position (Name of ematory or other place) Sylor Demotory	lace)		Oc. Location - City or	
21. Signature of Funeral Service License	ean CFSP	f	22. Name and Addr 10 Loway 07 Vine S	Funeral Hostreet, Po	Iome, Profe ocomoke Ci	emperancevil essional Associty, MD 21	re, va rejation
23a. Part 1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	lications that caused the death. ne cause on each line. a Due to (or as a conseque	h. Do not en	nter the mode of dy	ing, such as cardiac	or respiratory arres	it,	Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events c	b Due to (or as a conseque	lence of):					
cause (Disease of Injury that initiated events resulting in death) Last	c	ence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal (4 ☐ Pregnant at time of de	death 3[□ Ectopic pregnand	icy		23d. Date of deli Month	livery Day Year
Part II. Other significant conditions conf	tributing to death but not resul	iting in the u	nderlying cause give	ven in Part I,		acco use contribute to	o the cause of death?
					24a. Was an autopsy performe 1 □ Yes 2	24b. Were aut prior to c death? 1 ∐Yes	utopsy findings available completion of cause of
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	lospital: 1 ☐ Inpatient 2 ☐ E	FR/Outpatier	ent 3 DOA Oth	har:	th (Check only one)	ce 6 ☐ Other (Spec	
27. Mannar of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	of 28c. Injui Wor M 1 🗆	ury at ork? □Yes 2□No	28d. Describe how		ify)
4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or Rui State)	ral Route Number,
29a. Certifier 1	sician: To the best of my knowl ner: On the basis of examination and manner stated.	/ledge, death ion and/or in	n occurred at the ti	ime, date and place, opinion, death occur	, and due to the cau rred at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)
29b. Signature and title of certifier			200 Lines	se number	200	Date signed (Month	Day Voar

April 23, 2010

STUSBUM MB 2,804

DN 2

VEL NATESAN 31. Date filed (Month, Day, Year) APR 2 6 2010 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

parket

047094

5 DIVISION Sheet

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Patsy M. Creasy 2010 Medical 105-1 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death nty of Death ima Medical Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Months Days Min. 0311611947 Director Maryland 214-46-2536 63 Usual Residence of Decedent : If item 27 is marked other than "natural", or items 29a or 28a-f show or other traumatic event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland al Hygiene. 10b. County Director 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 X No Maryland Wicomico Parsonsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21849 32804 Mt. Hermon Rd. USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Verizon Be 17. Father's Name (First, Middle, Last) Should be filed and Mental H is marked of 18. Mother's Name (First, Middle, Maiden Surname) Willis Cooper Hilda Donoway off. Page 1 and 2 shours. To Health and Mr. To Health and Mr. To The Tries of Health and Mr. To The Tries of the Tries of 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32804 Mt. Hermon Rd., Parsonsburg, MD 21849 Fred Creasy husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other Wicomico Memorial 4 ☐ Donation 5 ☐ Other (Specify) 04 28 2010 Salisbury, Maryland 21. Signature of Funeral Service Livense 22. Name and Address of Facility Holloway Funeral Home P.A. 501 Snow Hill Rd., Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that cause the shock, or heart failure. List only one cause on each life. Immediate Cause (Final death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death -Filysician disease or condition Medical resulting in death) Due to (or as a consequence Examiner hosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or impury that initiated events Due to (or as a consequence of): Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed and I-tran Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical ON Division of Vital Records, P.O. Box 68760 IF FEMALE; 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year been signed by the should be detached 9 Unknown Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas e 2 s certificate has lirector, page 2 autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital ဂ္ဂ 1 🗌 Yes 2 No Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury accurred 1 Natural 5 Pending 1 Tyes 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State 24 hours a filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor **To the Fune** completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title 29d. Date signed (Month, Day, Year) 6464 Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Scramue

APR 26

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 22,^D2010 Anthony Donato Cianciarulo AMPIL 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital St. Mary's Leonardtown

3. Time of Death

3:40AM M

Physician/ Medical **Examiner**

the burial-transi and attending physician for use as the buria Division of Vital Records, P.O. Box 68760 ate has been signed by the atte page 2 should be detached for

Social Security Number 6. Sex 1 **X** M 2 □ F If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Days Nov 12, 1925 579 38 1407 Hours Director Pa. Country) 84 Usual Residence of Decedent or 28a-f show 10a. State with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City L<u>imits</u> XX 1 □ Yes 2 □ No Director Leonardtown MD St. Mary's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 40848 Hawk Court Funeral United States 20650 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ⚠ Yes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married Black, White, etc. þ Maryland 21215-0036 1 Yes 2 No Specify: "natural", White Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry iled within 72 h I Hygiene. (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important, If item 27 is marked other than any injury or other fraumatic. Elementary/Seconday (0-12) College (1-4 or 5+) Police Officer Law Enforcement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anthony Cianciarulo Theresa Girardi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 344 Chews Landing Road, Haddon Field, N.J. 08033 Tina Theodoris (daughter) Baltimore, 1 20a. Method of Disposition
1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 4 Donation 5 Other (Specify) Maryland Veterans Cemetery 4/29/2010 Cheltenham, Maryland Funeral Service 22. Name and Address of FacilityLee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition nset and set it Physician, Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Exami the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Year 4 Pregnant Pregnant at time of death g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed Yes 2 1 Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: Certificate: To npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 5 Pending Natural iniury s after death. Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David M. Federle, MD 24035 Three Notch Rd. Hollywood, Md. 20636 Registrar's Signatur Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Delores Millicent Physician/ Cusick Month Medical April 20th 2010 6:25 pm^M 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Genesis Health Care Waldorf Waldorf Charles . Age (In yrs. last birthday) **96** vre Funeral Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Month, Day, 1 🗆 M 2 🗶 Months Hours Min. Director 220-34-2860 Feb. Usual Residence of Decedent show 10a. State 10c. City, Town or Location Director 10d. Inside City Limits iral", or items 23a or 28a-f s Examiner must be notified MD Prince George's 1 Yes 2 X No Brandywine 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 15701 Bald Eagle School Road 20613 USA Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Completed by Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Specify: White 3 X Widowed 4 □ Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Louie Wines Ruth Frances Stamp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earl David Cusick/Son 6950 Orchard View Lane Hughesville, MD 20637 other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify Trinity Mem. Gardens Apr. 26,2010 Waldorf, Maryland 21. Sign up of Fune al Service Licensee 22. Name and Address of Facility Huntt Funeral Home 3035 Old Washington Rd. Waldorf, MD 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Pregnant at time of death Month Day Year signed by the a d be detached f 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performed certificate 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: ၉ 1 Yes 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work' s after death.

I Director: Aft
d in by the fur 2 Accident Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined hours a completed filled 24 hours Medical 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the 29b. Signature and title of certifier person who completed cause of death (Item 23a) (Type, Print) egistrar's Signatur Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	aryland	•	artment of F tificate of D		, 0	iene eg. No.? N	10	11.1.10	
	Physicia		Decedent's Name (First, Middle, William E Cot						2. Date of Death	h 🗔 🐱	Year	3. Time of Death 04:54am _M	
e da	Medi Examir		<u>William</u> E Cot 4a. Facility Name (if not institution, Southern Md Ho	give street and number)	_		4b. City, Town, or Clin	Location of Death		4c. County	of Death	orge	
	Funeral Director				(In yrs. last	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth		9. Birthp	place (State or Foreign	
		'n	Usual Residence of Decedent 10a. State 10b. County			Town or Loc	ation					0d. Inside City Limits	
	Marylar 28a-f sl	Director	MD Prince	George	Too. Oity,		ltenham			1 ☐ Yes 2★★			
	s 23a or	Funeral D	10e. Street and Number 10500 Brixt	on Lane			10f. Zip Code 20	0623	1	0g. Citizen of V	What Coun A.	try?	
9600	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ě	11. Marital Status 1 ☐ Never Marrled 2 丛Marri 3 ☐ Widowed 4 ☐ Divorced	1 20 100 2	ces? If Yes, specify Cuban, Mexican, Puèrto F 2 □ No 1 □ Yes 2 ☑ No Specify:					cify Yes or No- lican, etc.) 14. Race - American Black, White, etc Specify: B1a			
Baltimore, Maryland 21215-0036	vithin 72 ho jiene. er than "nat the Medica	Completed	15. Decedent (Specify only highes Elementary/Seconday (0-12) 12th			(Give k	ent's Usual Occupa ind of work done di NOT use retired ems Tech	ation uring most of worki	ing	16b. Kind of Business Industry Telephone Co			
land ;	d be filed vental Hygurked other tic event,	To Be	17. Father's Name (First, Middle, La	st) Elvin Cous	First, Middle, M Plassie	aiden Surname Bear	d						
, Mary	nd 2 should salth and N n 27 is ma er trauma			19a. Informant's Name/Relationship (Type, Print) Janie Cousin(Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S 10500 Brixton La Cheltenham Md 20623									
imore	Page 1 arment of He tant: If iten			1 x Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Md Vet Cemetery 4/22/2010 Chelte									
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Lic	ensee XX	1015	33 22.	Name and Address	s of Facility Lee 1d Alexar	Funeral	Home ry Rd	Clint	on Md 20735	
	Medical Examiner	iner	23a. Part 1. Enter the disease, or of shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Union, in the cause of the caus	omplications that caused it you cause on each line. a. Due to (or as a b. Due to (or as a	consequ	ce of):	the mode of dying	j, such as cardiac c	r respiratory arres	t,		Approximate Interval Between Onset and Death	
200	icate be executed ij physician and s the burial-transit	edical Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a	consequen	ce of):							
. Box 6876	To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Functal Director, After this certificate has been signed by the attending phy completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director.	Σ	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	23c. If yes, outcome of 1	Fetal de	eath 3	Ectopic pregnancy Other (specify)	,		23d. Dat Mor	e of deliver	ry Day Year	
ds, P.C	quires that I en signed b uld be detz	by	Part II. Other significant condition	s contributing to death but	not resultin	ng in the un	derlying cause give	en in Part I.	_			e cause of death?	
Division of Vital Records, P.O. Box	sician: The law rec certificate has be irector, page 2 sho	Completed							24a. Was an autopsy perform	ed? d	Vere autops prior to com leath?	sy findings available apletion of cause of	
Vital	ysician, iis certifii director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatien	t 2 5€ ER.	/Outpatient	Other	ce of Death (Check	<i>only one)</i> me 5 □ Residen	ice 6 🗆 Othe	r (Specify)		
on of	ending Pi sath. or: After th	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investiga		Year) 28	b. Time of injury	28c. Injury : work? M 1 \square	at 2	8d. Describe how				
Divisi	tal or Atture of all Directors	Certi	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		- At home (Specify)	, farm, stree	t, factory, office	2	28f. Location (Stre City or Town,		r or Rural F	Route Number,	
-	the Hospit nin 24 hour the Funera	Medical	Check 2 Medical Exa	hysician: To the best of m miner: On the basis of exa urse fractioner: To the be	mination an	id/or investia	ation, in my opinion	death occurred at:	the time date and	place and due	to the cause	batel and manner stated	
	0 With		29b. Signature and title of certified	lane 4			29c. License r		29	d. Date signed	(Month, Da	ay, Year)	
P	B1041			o completed cause of dea	th (Item 23:		restm R	ml, Fal	WASHI	etas n	10		
	Stat Registra	e r	31. Date filed (Month, Day, Year)	010 32/Registrar's	Signature	per	W						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MPRIL 2090 **Physician** 6:15 A-M Rick Kenneth Caple /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** PERRY WAKAYUND HEALTH CARE 5YSIEM If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, March 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, Year) 1951 **Funeral** Months Days Washington 59 537-52-9987 Director Usual Residence of Decedent 10d. Inside City Limits Sa or 28a-f show the notified at 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No **Funeral Director** Maryland Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 818 Coconut Court 21014 U.S.A. 7 is marked other than "natural", or items 23a traumatic event, the Medical Experience in ust to 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1969-71 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 👿 No Specify Completed by Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Robert Larson's Toyota 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)
Twelve Years College (1-4or 5+) Tacoma, Washington General Sales Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be of Health and Mental Joann Butchcoe Kenneth Caple ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (wife) 21014 818 Coconut Court, Bel Air, Maryland Vicki Lynn Caple 20c. Location - City or Town, State West Chester. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Important: If it any injury or o once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State R.A.Ferris & Co.. Incl 04/27/10 Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Lee A. Patterson & Son Funeral Home,
Perryville, Maryland 21903-0766 21. Signature of Funeral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final CHRONIC OBSTRUCTIVE PULMINARY DISTRUCTIVE PULMINARY PULMINARY DISTRUCTIVE PULMINARY PU Approximate Interval Between Onset and Death PULMONARY DISEASE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): END STAGE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner that initiated events resulting in death) Last for use as the burial-tran Due to (or as a consequence of): physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day Vear 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? TON 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate 1 ☐ Yes 2 ☐ No 2 ANO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2ÃNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, To the Hospital o within 24 hours aff To the Funeral Di

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Maryland

NAME ANOWN T Baltimore, N

P.O. Box 68760,

Pages 1 and 2

1+1VA

State Registrar 31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year **2010** Physician APRTT. 20. CAMPRELI EDWARD

Physic /Med		JOSEPH EDWARD CAMPBELL			0, 2010 07:00A M
Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
		PRINCE GEORGE'S HOSPITAL CENTER	CHEVERLY		PRINCE GEORGE'S
Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 1	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 9/4/1956	
and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Li	ocation		10d. Inside City Limits
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the N 28a-	Director	Maryland Prince George's Capito	1 Heights 10f. Zip Code	10g. (Citizen of What Country?
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leath	era	6801 Greig Street 11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		ited States 14. Race - American Indian,
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5 + £ € € .			22. Name and Address of Facility Pop	e Funeral	linton, Maryland Homes, P.A.
Depariming Department on the suny It		Charles E. young 5:	538 Marlboro Pike	Forestvill	le. Maryland 20747
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Physician		Immediate Cause (Final			Interval Between Onset and Death
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Examine		Sequentially list conditions b.			
D #	ne.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
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that had be detailed	H-	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
w requires to been signer should be	d by			1 ☐ Yes	2 No 3 Probably 4X Unknown
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The la	dwo	CRITICITY OF THE PARTY		autopsy performed 1 Yes 2 X	prior to completion of cause of ? death? No 1 □ Yes 2 ☑ No
	(a)	25. Was case referred to medical	26. Place of Deat	th (Check only one)	10 100 2010
Physician: r this certificated rail director, i	0.0		Other:		e 6 □Other (Specify)
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I or Attend after death. Director: /	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury · At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
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0 1		30. Name and address of person who completed cause of death (Item 3a) (Type		0	110110
RL		Margaret Akpan M.D. 3001 Hospital Dr	ive Cheverly, Mary	land 2078	5
S	tate	31. Date filed (Month, Day, Year) 32. Registrer's Signature)		
Regis	trar	ADD 272010 Census D. Alarka			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10:00 2010 Vaughany Mae Casey 04 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1000 Brightseat Road Apt. 250 Prince George's Landover Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Months Davs Hours Min. Director 65 Yrs. 05/17/1944 27-60-8781 Penhook Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location with the Maryland the Medical Examiner must be notified at Director 10d. Inside City Limits 1 X Yes 2 ☐ No MD Prince George's Landover 10f. Zip Code ò 10e, Street and Number 10g. Citizen of What Country? Funeral items 23a 20785 1000 Brightseat Road Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ò ģ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Completed Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working al Hygiene. Federal Government life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Personnel Officer Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ Jessie James Casey Annie Lee Board 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Alicia Jackson - Daughter 2707 Scarborough Drive Ft. Washington, MD 20744 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 K Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Casey Family Cem. 04/25/2010 <u>Penhook, VA</u> Signature of Funeral Service Licensee 22. Name and Address of Facility Ft. Lincoln Funeral Home, Honga Montgomen Brentwood, MD 20722 reatten 3401 Bladensburg Road 23a. Part 1 Inter the disea or recompletions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Atherosclerotic Cardiovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 Yes 2 2 9 Unknown 2 🔀 No by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes Mellitus 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy certificate ha 2X No 1 Yes 2 No Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? X Natural 5 Pending s after death.

Director: After in by the fur 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) City or Town, State) Medical 1 🚨 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year. 29c. License number

2_ 10 State

Registrar
DHMH 17 Rev 7/2009

works

William R. Frederick,

31. Date filed (Month, Day, Year,

APR 2 7 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registar's Sig

MD 106 Irving Street, NW # 304

4502DC

April 23, 2010

Washington, DC 20010

DHMH 17 Rev 1/2001

Registrar

31. Date filed

selonick.

MO

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2237 M 2010 Joseph Angelo Cilione Medical 4a. Facility Name (if not institution, give street and number) County of Death **Examiner** 4b. City, Town, or Location of Death Regional Medical 8. Date of Birth May 25, 1936 If Under 1 Year 9. Birthplace (State or Foreign **Funeral** Sex 1 M 2 □ F Days Months Hours NewYork Director 082-32-1348 73 Usual Residence of Decedent "natural", or items 23a or 28a-f show adical Examiner must be notified at 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1X Yes 2 ☐ No Maryland Wicomico Delmar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21875 IISA 9256 Clare Circle Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces? ve Unknown Years by 1 X Yes 2 If Yes, Give Baltimore, Maryland 21215-0036 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 N Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Long Haul Freight Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Angelo Evangeline (Maiden Surname Unknown) Cilione 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen J. Smith/Companion 9256 Clare Circle, Delmar, Maryland 21875 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State permit. Page Department of Important: If any injury or Crematory of Delmarva 4/20/2010 Delmar, Delaware 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Li Zeller Funeral Home, P. O. Box 3171 1212 Old Ocean City Road, Salisbury, MD 21802 Pay 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Parcrachis disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Congula part Sequentially list conditions. Examiner cause. Enter Underlying Cause (Disease or linjury Due to (or us a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death 2 \square No 1 ☐ Yes 2 ☐ Unknown 9 Unknown **To the Funeral Director:** After this certificate has been signed by a completed filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ > No Completed 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **X**No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 \square Pending 1 Yes 2 🗌 No Accident Suicide Investigation thin 24 hours after deat the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) with ying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within To the 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAlisbury, Md. 21801 Chin mo 31. Date filed (Month, Day, Year)

APR \$2 2010 State Registrar

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Charles Herbert Cook, Sr. 810 M 10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Deat 4c. County of Death 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth (Month, Day, Year) 1 XM 2 □ F Months Days Hours Min Washington, DC **Director** 578-18**-**6985 90 Usual Residence of Decedent items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at **Funeral Director** Maryland Anne Arundel Mayo 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21106 USA 312 Poplar Avenue 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ō þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 X Widowed 4 □ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Machinery Engineer Meat Packing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Frederick Cook Rose Lillian Boarman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28360Linda Oxendine/Daughter 707 Back Swamp Road, Lumberton, North Carolina 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 X Removal from State Garden of Faith Cem. 4/27/2010 4 Donation 5 Other (Specify, Lumberton, NC 21. Signature of Funeral Service Lice ²² Name and Address of Facility Zeller Funeral Home, P. O. Box 3171 1212 Old Ocean City Road, Salisbury, MD 21802 . Part 1. Enter the disease, or complications shock, or heart failure. List only one cause hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ congestive card wmy opa disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 E FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an s certificate has the lirector, page 2 s performe Be (25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 5 Pending injury 1 Natural work? 2 🗌 No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in t 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 within 2 To the 1 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Penincula Regional Medical Center Salisbury my harles Via 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death Reg. No.2 11 1

			_ FOr	partment of Health and I	Mental Hygie	ene
			- Togotici	ertificate of Death	Reg.	No2() () 44/
	Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month APRIL 22	Day Year 2010 3. Time of Death 5:32 P M
	/Medic	cal	ANNA BRAMBLE COLLISON 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		2 2010 5:32 P M
	Examin	ier	CHESAPEAKE WOODS	CAMBRIDGE	'	DORCHESTER
T	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	ay) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign
	Director		217-16-9341 ^{1□ M 2} ▼F 91 Yrs	Months Days Hours Min.	AUG. 11,	9. Birthplace (State or Foreign Country) MARYLAND
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town o	Location		10d. Inside City Limits
	Marylan-f show	ঠ	MARYLAND DORCHESTER RHODESDA	I F		1 □Yes 2 No
5	r 28a	Director	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Country?
5	23a o		4913 RHODESDALE-ELDORADO ROAD	21659		USA
) .	r dea tems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (Spirityes, specify Cuban, Mexican, Puerto 	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.
3	s affe	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 ሺ No If Yes, Give 3 ሺ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 XNo Specify:		Specify: WHITE
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	be filed within 72 hours after death with the Maryls Atal Hygiener Ad other than "natural", or items 23a or 28a-f shor event, it a Medical Examinar must be notified at	Be	17. Father's Name (First, Middle, Last)	1.00	ne (First, Middle, Mai	iden Surname)
, :	2 should be filed within 72 hours after death with the Maryland i and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examinar must be notified at	ပ	OTIS BRAMBLE	DEROTH.		Strag Town State 7th Code)
3	Ithan Ithan 27 is r traur			BEACH HAVEN ROAD,		
<u>.</u>	f Hea f Hea item (·	sposition (Name of crematory or other place)		c. Location - City or Town, State
	rage nent o nt: if		1 23 Burial 2 Li Cremation 3 Li Removal from State		5/2010 BR	OOKVIEW, MARYLAND
5	permit. Pages 1 and 2 should be lited within 12 Department of Health and Mental Hygiene, important: if item 27 is marked other than "in any injury or other traumatic event, in a Media once.		21. Signature of Funeral Servide Udensee	22. Name and Address of Facility ZELLER FUNERAL HOM 106 MAIN STREET, E.		
		(23a. Pay 1. Enter the disease, or complications that caused the death. Do not			Approximate
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5	attending p	M/W	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death	2		23d. Date of delivery
	The favirequies final the death evinineate ate has been signed by the attending physoage 2 should be detached for use as the	Physician/Me	in the past 12 months? 1 □ Yes 2 Datho 9 □ Unknown in the past 12 months? 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year
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	s peen s	Completed	Ostroacthritis, Anasacca	Renal Tumos	24a. Was an	24b. Were autopsy findings available
	ate ha	mo	2 11 21 15 21	Trained Horis	autopsy performe 1 □ Yes 2	prior to completion of cause of death? No 1 □ Yes → No
		Be C	25. Was case referred to medical examiner?	26. Place of Dea	ath (Check only one)	910 7200
	this co	၉	1 ☐ Yes 2 ☐ No ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa			ce 6 Other (Specify)
	After funera	ion:	27. Manner of Death Matural S Pending 28a. Date of Injury 28b. Time	28d. Describe how	injury occurred	
	Attending Finystolans, in death. ector: After this certific by the funeral director.	fica	3 Suicide 6 Could not be 28e, Place of Injury - At home, farm			et and Number or Rural Route Number,
	rs after sa and	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town, S	State)
incoll o	or in robytical or Archining rupsicality within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifler (Check only one) Certifying Physician: To the best of my knowledge, companies to the desired for the pass of examination and/or and manner stated.	eath occurred at the time, date and place or investigation, in my opinion, death occu	e, and due to the cau urred at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
Ę	withir comp	Me	29b. Signature and title of certifier	29c. License number	/ C 29d	. Date signed (Month/Day, Year)
			for a fam Dio.	H 476	1)	4/26/200
			30. Name and address of person who completed cause of death (Item 23a) (Ty	th 446 De, Print) DO Bramble park	5+ 0	an bridge
	Sta Registr		31. Date filed (Month, Day, Year) APR 27 2010 APR 27 2010	barkel	<u> </u>	
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		for State		State of Ma	arylan					Mental H	ygiene	9010	1 1 1,	1.18
		Registrar 1. Decedent's Nam	o (Cinot thindello 1				Certifica	e or	Death	2. Date of D	Reg. No	CUIL	2 Time	of Death
Physic	ian	Emily			Cre	ocett	1			Month April	Da	y Yea	r	O A M
/Med Exami			Juc If not institution, gi	ive street and number)		3000		, Town, o	r Location of De			County of De		U A
LAdiiii	1161	,	Nursing				Sar	dy S	Spring			Montgo	nery	
Funeral		5. Social Security N	lumber 6.	Sex 7. Age		last birtho	Months	r 1 Year Days	If Under 24 H Hours M	in. (Month, E	Day, Year,	irthplace (State Country)	_	
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/land ow at		10a. State	10b. County		10c. Cit	y, Town o	r Location						10d. Inside	City Limits
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ith the or 28	Director	10e. Street and Nu						o Code				tizen of What	Country?	
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ter de Item:	Funeral	11. Marital Status	ried 2□ Married	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 📉 N		.5.				(Specify Yes or Nuerto Rican, etc.)	10-	Black, W		
urs af	b l	3 Widowed		If Yes, Give Year or Dates:			1 ☐ Yes	2[X] No	Specify:			Specify: W	nite	
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and Mand Mand Mand Mand Mand Mand Mand M		19a. Informant's N	ame/Relationship	(Type. Print)		19b. N	failing Addres	s (Street	and Number or	Rural Route Num	ber, City	or Town, State	e, Zip Code)	
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ges 1 For H		20a. Method of Dis		□Removal from State	20b. F	Place of D cemetery,	isposition (Na crematory or	me of other pla	ce)	Date	20c. L	ocation - City	or Town, State	
t. Pa rtmen rtant: rjury		4 □ Donation 21. Signature of F	5 Other (Spec		King	Davi				or. 14, 20		alls Ch	urch, V	7A
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medikal Examiner must be notified at anone.		21. Signature of F	uneral Service Lic	of the second	_		Jeffe 5755	rson	Funera	l Chapel n Dr., A	lava	ndria	VΔ 223	15
		23a. Part1. Enter	the disease, or co	mplications that caused	the deat	h. Do no						narra,	Approxin Interval	
Physician		Immediate Cause disease or condition	(Final	y one cause on each lir		ru f	ate.	De	76676				Onset ar	id Death
/Medical		resulting in death)	1	a. Coro	a conseq	uence of)	: 10/24						7	41
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ng ph	Physician/Medica	IF FEMALE:												
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that ted by		Part II. Other signi	ificant conditions	contributing to death be	ut not res	ulting in t	ne underlying	cause giv	ven in Part I.	23e. Did	tobacco	use contribute	to the cause	of death?
quires n sign ald be	d by	Chroni	i obstru	active luna	Disc	use				_ 10	Yes 2	2 No 3 □	Probably 4	□Unknown
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The I	l Lio					-				— au pe 1□ Yes	topsy rformed? i 2∭N	death		il cause of
clan: ertifica	Be C	25. Was case refe examiner?	rred to medical							Death (Check only				
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ding I	ioi	1 🛚 Natural	5 ☐ Pending investigation	(Month, Day	y Year)	Inji		28c. Inju Wo	ryai rk?]Yes 2∐No	28d. Describ	e now inju	ury occurred		
Attending Physician: The lavar death. rector: After this certificate has by the funeral director, page 2.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 4 Homicide 4 Homicide 4 See. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number or State) 28f. Location (Street and Number or Rural Route Number or Town, State)									lumber,			
s after	Sert	4 Homicide		building, et	с. (Бресп	<i>(y)</i>				City or I	own, Stai	re)		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ledical (29a. Certifier (Check only		Physician: To the best aminer: On the basis o										e(s)
thin 2, the I thin 2, the I mplet	Med	29b. Signature and	title of certifier	and manner sta			2	c. Licens	se number		29d D	ate signed (M	onth, Day, Yea	r)
F 18 F 8		b Z	1 -	20				018	726		Ap	ril 13.	2010	,
10		30. Name and add	ress of person wh	o completed cause of d	eath (Iter	n 23a) (T	ype, Print)							
- ld		ARTIHAR	SCHOE	-NGOLD MC	>	1811	1 Pr.	ice !	Philop Dr	7-10, 0	LNE	4, 40.	20832	
Si Regis	tate	31. Date filed (Mor	nth, Day, Year)	32. Registr	r's Sign	dure L				•	/	/ /		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 24a per phys. G904 6/2/10 dk
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Apri Physician/ 2010 11:30 P™ Gerald D. Casto Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospice of Chesapeake Anne Arundel Harwood <u>Mandrin House,</u> If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Security Number 8. Date of Birth (Month, Day, Year, **Funeral** 1 **X** M 2 □ F <u>West Virginia</u> **Director** 234-56-5225 72 entember3 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes XX No Maryland | Prince Georges Forestville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Be Completed by Funeral USA 2810 Ocala Avenue 20747 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates:1957-1963 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Phone Company</u> 12th Repair 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Audrey Kelly Frantz Casto 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2810 Ocala Avenue, Forestville, MD. 20747 Jean Casto/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition X Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Trinity Memorial Gdn | April 27, 2010 Waldorf, Maryland 22. Name and Address of Facility Huntt Funeral Home 21. Signature of Funeral Service Licensee 400544 3035 Old Washington Rd. Waldorf, MD 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between On et and Immediate Cause (Final ADENO CARCINOMA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentiany liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Yes 2 9 Unknown 2 🗌 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy death? performed' 1 🗌 Yes 2 🗆 No 1 ☐ Yes 2 🗷 No 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Be Hospital: Other: 4 Nursing Home 2 5 Residence 6 Other (Specify) မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 5 Pending 2 🗌 No 1 Yes 24 hours after death. Funeral Director: A Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Gertifying Nurse Practicines To the best of my in civil age, depth concurred at the films, date and plane, and due to the newselfs and manner as state within 2 To the the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Mgnth, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) # 201 CLINTON MD 20735 WOODYARN 8926 M State Registrar

			For 4-20-10	State of Maryland	d / Depa	artment of He	alth and Me				
	Physicia		1. Decedent's Name (First, Middle, Last)			tificate of De		2. Date of Dea		3. Time of Death	
	Physicia Medic	al	4a. Facility Name (If not institution, give str	K. Copeli	end	th City Town and a	easting of Dooth	Month 4	- 1 ^{Pay} - 10 ^{Year}	12)45am	
	Examin	er	JOSEPH RITCHIE			4b. City, Town, or Lo			4c. County of Death BALTIMORE		
	Funeral Director		210 32 0371 1	7. Age (<i>In yrs. la</i>	st birthday) Yrs.		Hours Min.	B. Date of Birt (Month, Day FEB 7	th 9. Bir 1949 VIF	thplace (State or Foreign ountry) CGINIA	
	and show d at	or	Usual Residence of Decedent 10a. State 10b. County	10c. City	Town or Loc	ation				10d. Inside City Limits	
	e Maryk r 28a-f notifiec	Jirect	MD PRINCE GEO	ORGE'S U	PPER M	ARLBORO				Y Yes 2 No	
	with the 23a or	Funeral Director	10e. Street and Number Chesterton 12110 CHESTERSON I	ORIVE		10f. Zip Code 207	74		10g. Citizen of What Co	ountry?	
	r death r items iner m		11. Marital Status	2. Was Decedent Ever in U.S	If	Vas Decedent of Hispa Yes, specify Cuban,	_	fy Yes or No- can, etc.)			
14/20/0Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by	1 Never Married 2 Married 3 Widowed 4 Divorced	1X Yes 2 □ No NA' If Yes, Give Year or Dates.	V Y 1	☐ Yes 2 ☐XNo \$	Specify:		Specify: BLA	ACK	
215-(היסל 27 רסו an "nat Medica	mple	15. Decedent's Educ (Specify only highest grade Elementary/Seconday (0-12)		(Give k	ent's Usual Occupation ind of work done duri O NOT use retired)	on ing most of working	,	16b. Kind of Business	Industry	
212	d withir lygiene ther th	Be Co	12TH	College (1-4 of 57)	_POLI	CE OFFICER			GOVERNME	ENT	
land	be file lental F rked of ic ever	To B	17. Father's Name (First, Middle, Last) SAMUEL COPELAND			18	8. Mother's Name (ALICE U		-		
/O Mary	should and M ris mai raumat		19a. Informant's Name/Relationship (Type		19b. Mailin	g Addrass (Street and			r, City or Town, State, Zi	(A D.V.I. AND	
e, S	1 and 2 if Health item 2; other t		NOREEN COPELAND/W3 20a. Method of Disposition	20b. Pl	ace of Dispos	sition (Name of	DRIVE Da		20c. Location - City or		
timo	Page tment c tant: If jury or		1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	emoval from State RI		atory or other place) E CREMATOR			RIVERDALE,M		
Bal	permit Depar Impor any in		1. Signature of Funeral Strike Licensee	NKINS FUNER ER,MARYLANI							
4			23a. Part 1. Enter the disease, or compile shock, or heart failure. List only one	cause on each line.		1 1	3 2	respiratory arr	rest,	Approximate Interval Between Onset and Death	
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence	K With	n metaataa	i to bia	en, sp	ini demin	Onset and Death	
	Examiner	er	Sequentially list conditions, b.	Due to (or as a consequence	ence off:						
	cuted nd ransit	cal Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events								
0	be executed sician and burial-transit	ical E	resulting in death) Last	Due to (or as a consequ	ence of):						
68760	rtificate ing phy e as the	/Wed	IF FEMALE:								
() Box 6	or Attending Physician: The law requires that the death certificate after death. Director: After this certificate has been signed by the attending phys in by the funeral director, page 2 should be detached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregnar 1 Live Birth 2 Fetal 4 Pregnant at time of decentions 9 Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year	
F.0.	that the ned by the detach		Part II. Other significant conditions cont	ributing to death but not resu	lting in the ur	nderlying cause given	in Part I.	23e. Did to	obacco use contribute to	the cause of death?	
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PELRecords	> S S	Completed by		3					osy prior to death?	rtopsy findings available completion of cause of	
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of Vi	g Physi er this c ieral dire	te: To	27. Manner of Death	1 Inpatient 2 I	28b. Time of	28c. Injury at			dence 6 XOther (Spec	sity) HOSPICE	
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A	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page.	Medical	29a. Certifier (Check only one) 3 Certifying Physic Certifying Physic Certifying Nurse Certifying Nurse Certifying Nurse Certifying Nurse Certifying Nurse Certifying Nurse Certifying Nurse Certifying Nurse Certifying Nurse Certifying Nurse Certifying Nurse Certifying Nurse Certifying Nurse Certifying Nurse Certifying Nurse Certifying Physic Certifying	ian: To the best of my knowle r: On the basis of examination Practioner: To the best of my	dge, death o and/or investi knowledge, d	ccured at the time, da gation, in my opinion, of eath occurred at the tire	ate and place, and death occurred at the	due to the cau ne time, date a and due to the	use(s) and manner as st and place, and due to the e cause(s) and manner as	ated. cause(s) and manner stated.	
_	To the within ? To the сотріє	2	29b. Signature and title of certifier			29c. License nu	umber		29d. Date signed (Mont		
			30. Name and address of person who com	npleted cause of death (Item	23a) (Type, P	rint).	164267		4-1	470	
VI.	45		Dr. Karen	CONJINJ-BREL	n	827 1	inden A	V . (Back Mo. a	2/20/	
	Stat Registra	e ar	31. Date filed (Month, Day, Year) APR 1 8 2010	32. Registra's Signa	a Marie						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MA 00 PO انع 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Prince Georges Hospital Center Cheverly . Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 1 □ M 2 X F Days Hours NOV. 23, 1923 Yazoo, Miss. 413-26-3307 86 Director Usual Residence of Decedent or 28a-f shov Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Marvland Prince Georges Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8907 Hilton Hill Drive 20706 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【XNo 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Installation Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file of Health and Mental fitem 27 is marked of ည William L. Clark Dora B. Severs 19a. Informant's Name/Relationship (Type, Print) Christine Meledick (Daughter) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8907 Hilton Hill Dr. Lanham, MD 20706 20b. Place of Disposition (Name of cemetery, crematory or other place)

Mount Olivet Cemetery 4/21/2010 20a Method of Disposition 20c. Location - City or Town, State Page 1 1 Durial 2 Cremation 3 Removal from State Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rendon/Hale Funeral Home Signature of Funeral Service License 9013 Annapolis Rd. Lanham, MD 20706 23a. Part 1. Enter the discusse, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death 6211612dder Immediate Cause (Final 2:totect Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Physician/Medical Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-transi Due to (or as a consequence of): P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 month Month Day Year signed by the a Id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Tes 2 No 3 Probably 4 Tunknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy autopc, performed: 2 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Yes မှ ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Man r of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 24 hours after death. work? 1 Natural ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 👺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Marse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 15 2010 46 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20785 No. 31. Date filed (Month, Day, 32. Registrar's Sign iture State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 20 ay 2010 ar Charles Camp Dixon Jr. 0609A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Kent Chester River Hospital Center Chestertown Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □XM 2 □ F Hours 1/5/1916 Country) Director 219-36-0390 94 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 □ No MDKENT Chestertown 10e. Street and Number 10a. Citizen of What Country? Funeral 100 Hadaway Dr. 21620 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ANo Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, by 1 Never Married 2 Married Yes Yes, Give Maryland 21215-0036 1 Yes 2 No Specify Specify: 3 X Widowed 4 □ Divorced Completed White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry ift. Page 1 and 2 should be moon artment of Health and Mental Hygiene. Fortant: If item 27 is marked other than "no contant: If item 27 is marked other than "no contant." (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Farming & State Hwy Admin. State of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles F. Dixon Susan W. Camp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert S. Dixon/son 1403 Theodore Rd. Port Deposit, MD 21904 Baltimore, Important: If item any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of 1 🗌 Burial 2 🖾 Cremation 3 🗌 Removal from State 4 Donation 5 Other (Specify) Chesapeake Cremation 4/21/10 Stevensville, MD 21. Signatu e d Funeral Service Licenses ²² Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home 130 Speer Rd. Chestertown, MD 21620 sease, or complications to 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ch line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Keumery disease or condition Medical resulting in death) o (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or impury that initiated events and burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months? Month Year Pregnant at time of death Yes 2 No the g 🗌 Unknown P.O. I been signed by should be detac resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate 1 Yes 2 Ho Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After t (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation
6 Could not be To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completed filled in by the fu death. Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗖 only one 29d. Date signed (Month, Day, Year) 29b. Signaty and title of confifie 29c. License number 8006030 cause of death (Item 23a) (Type, Print) 30. Name and address of person who complete STES CHERTOLITAIN, MAI) 21620 FIMEN W MS 31. Date filed (Month, Day, Year) 32. Regisar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** COO FM June Frances Day 3010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** CHARL CIVISTA MEDICAL Birthplace (State or Foreign Country) 7. Age (In yrs. 71 Date of Birth (Month, Day, Social Security Number last birthday) Funeral Months Days Hours 1 □ M 2 💢 F 577-54-2862 Maryland Feb. 1939 **Director** Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location if than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Charles Maryland Nanjemoy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20662 U.S.A. 3950 Deacon Dent Place Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2√2 No Specify Specify: 3 ☑ Widowed 4 ☐ Divorced Black 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 2121 Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Her Home 11 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname, Maryland 17. Father's Name (First, Middle, Last) Be 1 and 2 should be fi Health and Mental F Katie Proctor John Dent ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 street of Health a 11366 Stoney Cove Dr., Waldorf, Md. 20602 Geraldine Dent Sister permit. Pages 1 an De artment of Hear Important: If item 2 an, Injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) April 30, 2010 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State Nanjemoy, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Mount Hope Baptist Church 22. Name and Address of Facility
Williams Funeral Home, P.A. 21. Signature of Funeral Service License M00668 4270 Hawthorne Rd., Indian Head, Md. 20640 ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ure. List only one cause on each line. 23a. Part 1. Enter the c shock, or heart fa Approximate Interval Between Onset and Death Immediate Cause inal Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed a attending physician and for use as the burial-trans Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) detached 9 Unknown s been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 2 No 1 Yes 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? page 2 s certificate has 2 □No 1 □Yes 1 ☐ Yes director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) funeral 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation after death. 2 Accident 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death accurred at the time. 29a. Certifier Medical completely (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, DavA Year, ed cause of death (Item 23a) (Type, Print) 31. Date filed (Month State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 19,2010 14:40 P M Robert Eugene Dreisbach Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Months 302 46 4364 1 X M 2 🗆 F Days Hours Ohio Septen 27 pay 1949 Director 60 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Forestville 1 🗆 Yes 2 🗖 No 10f. Zip Code 10g. Citizen of What Country? Funeral 3704 Kingswood Drive 20747 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 X Yes 2 No Black, White, etc. 2 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 XNo Specify: Vietnam Specify: White Completed 3 Widowed 4 Divorced Year or Dates. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 7 and Mental Hygiene. 7 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Retired Airforce U.S. Marshal Dept of Justice Be other traumatic event, 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Dorothy M. Harrison Harry L. Dreisbach permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic to 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rufina Dreisbach (Wife) 3704 Kingswood Drive , Forestville, MD 20747 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cemetery 4/28/2010 4 Donation 5 Other (Specify) Cheltenham, Maryland 22. Name and Address of Facilities Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 Signature of Funeral Service Licensee Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perforn 1 🗌 Yes 2 🗆 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) P 2 XNO Other: 1 Tes 1 Inpatient 2 R/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one lying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. certifier 29b. Signature and title of 29d. Date signed (Month. Dav. Year) Name and address of person who completed ca se of death (Item 23a) (Type 12 31. Date filed (Month, Day, Year)

Registrar

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. within 24 hours a To the Funeral C completely

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Medical

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4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 1 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) D68995 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hagerstown, NAD 21740 opal 1130 32. Registrar's Signature **ORIGINAL**

Please Type or Print in Black Indelible Ink. E	nsure All Copies Are Legible.							
State of Maryland / Department of Health and Mental Hygiene								
Certificate of De	eath Reg. No.							
irst, Middle, Last)	2. Date of Death							

			1- State of Maryland /		rtment of Heal tificate of Dea			ene g. No. 🤈 🕦 📗	0 141.25		
	Physici	an	1. Decedent's Name (First, Middle, Last)			2.	Date of Death Month		3. Time of Death		
	/Medic		George L. Daelemans, Jr.		4			4/18/2010 Year 1405 M			
	Examiner 4a. Facility Name (If not institution, give street and number)							4c. County of De			
			Anne Arundel Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last	hirthday)	Annapolis If Under 1 Year If Under 24 Hrs. 8, Date of Birth			Anne Arundel			
	Funeral Director		5. Social Security Number 153-26-7558 6. Sex 7. Age (In yrs. last 153-26-7558 75	Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Months Days Hours Min. Months Days Part of State Months Mont)34 S	9. Birthplace (State or Foreign Country) NY		
	and w	al Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, To	own or Loc	ation				10d. Inside City Limits		
21215-0036	Aaryle f sho		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □ Yes 2X No								
	the the 28a-		10e. Street and Number	Webe	10f. Zip Code		10	g. Citizen of What C	country?		
	h with 23a or		927 Georges Lane		207	78		USA			
	ems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	/as Decedent of Hispan Yes, specify Cuban, Me	nic Origin? (Specif	y Yes or No-	14. Race - Am Black, Wh			
	2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Modical Eventret must be notified at	by Fu	1 ☐ Never Married 2 Married 1 ☐ Yes 2 Mo If Yes, Give 1 Yes, Give Year or Dates:		□Yes 2¥12¥No <i>Sp</i>		,	Specify:	White		
<u>ئ</u> 1	72 hou	Completed	15. Decedent's Education (Specify only highest grade completed)	6a. Deced	ent's Usual Occupation	a most of working	1	6b. Kind of Busines	s/Industry		
Z	ithin ne.	ld m	Flementary/Secondary (0-12) College (1-4or 5+)		ind of work done during O NOT use retired) Crical Engi		Coddard	Goddard Space			
7	iled w Hygie ther t		17. Father's Name (First, Middle, Last)	Етес		Mother's Name (F	First Middle M		Брасс		
yland	d be f ental I ked of c eve	o Be	George L. Daelemans, Sr.			Helen Ma					
35	shoul	2		9b. Mailin	Address (Street and N	Number or Rural R	Route Number,	Cify or Town, State,	Zip Code)		
<	alth a				eorges Lane			MD 20778			
ore	es 1 a of He fitem		20a. Method of Disposition 1 ☐ Burial 2★★ Cremation 3 ☐ Removal from State	e of Dispos etery, crem	ition (Name of atory or other place)	Date	e 2	0c. Location - City o	r Town, State		
baltimore,	Pag tment tant: I		4 Donation 5 Other (Specify) Atla		Crematory	4/23/		Glen Burn			
מ	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any Injury or other traumatic er		21. Signature of Funeral Service Licensee		Name and Address of P			neral Homo , MD 2140			
			23a. Part 1. Enter the disease, or complications that caused the death. D						Approximate Interval Between		
∖ P	Physician	jr.	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition SCOS i.S.)								
	/Medical Examiner		resulting in death) Due to (or as a consequence)		`						
	Lxammer		Sequentially list conditions, if any leading to immediate b. Let of consequence of: Due to (or as a consequence of):								
	uted I Insit	mine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events b. Due to (or as a consequence of): Chemotherapy.								
'n.	exection and and rial-tra	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c. Chemotherapy. Due to (or as a consequence of):								
00/00	rificate be executed ng physician and as the burial-transit	edical	L. Lung Car	1ce	· .						
ŏ	ding page as		IF FEMALE:								
200	eath c atten for us	sician/N	23b. Wes decedent pregnant in the past 12 months?						23d. Date of delivery Month Day Year		
į	the d	Physi	1 Yes 2 No 9 Unknown 9 Unknown								
Ų.	s that gned b	by PI	Part II. Other eignificent conditions contributing to death but not resulting	g in the un	derlying cause given in I	Part I.	23e. Did toba	acco use contribute	to the cause of death?		
colds,	equire	ed t					1 ☐ Yes	s 2 X No 3□ I	Probably 4 Unknown		
ב ע	law r las be	ple					24a. Was an autopsy	24b. Were a	autopsy findings available completion of cause of		
Completed Comple								performed? death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No			
2	sician certifi rector	Be	25. Was case referred to medical examiner? Hospital: Hospital:		Othor	Place of Death (C					
5	Phys r this ral dii	To	To Tes Zinpatient 2 ER/	Outpatient D. Time of	3 DOA Other. 4			nce 6 Other (Sp w injury occurred	ecify)		
5	ading th. : Afte e fune	Certification:	1/Mavatural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident investigation	Injury	Work? M 1 ☐ Yes		2. Describe nov	winjury occurred			
2	Atter	ifice	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined building, etc. (Specify)	farm, stre	et, factory, office	28f.	Location (Stre	eet and Number or I	Rural Route Number,		
5	ital or Irs afte ral Dir led in	Cert									
	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use.	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination and manner stated.	dge, death and/or inv	occurred at the time, de estigation, in my opinior	late and place, and n, death occurred	d due to the ca at the time, da	iuse(s) and manner ite and place, and di	as stated. ue to the cause(s)		
	76 th Veithir Сощр	Me	29b. Signature and fittle of certifier		29c. License num	nber	29	d. Date signed (Mor	nth, Day, Year)		
			Steph Oso, mo		D585	510		04/18/	10		
	C H4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen Olero AAMC 2001 Medical Parkway Annapolis, MD 21401								
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature								
	negistr	aı	nilla-roid Report	~· 19							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DONALDSON APR) HARLES 0140AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner DLNEY MONTGOMERY GENERAL MONTGOMERY HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth g. Birthplace (State or Foreign Funeral 1**XX**M 2 □ F Days 8 727 / 1934 75 DC Director 217-34-2060 Usual Residence of Decedent show 10c. City, Town or Location 10a. State 10d. Inside City Limits 72 hours after death with the Maryland Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 Yes XX No Montgomery Clarksburg 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 12601 Clark Meadows CT. 20871 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black. White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2X No Specify 3 X Widowed 4 ☐ Divorced Completed Year or Dates and Mental Hygiene.
is marked other than "natur
aumatic event, the Medical I Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Mailer Washington Post Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charles Edward Donaldson Margaret Clubb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other tratonce. Clark Meadows Ct. Clarksburg, MD 20871 Michael Donaldson Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 4/24/2010 | Clinton, MD Signature of Funeral Souice Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CONGESTIVE HEART hours disease or condition Medical resulting in death) Examiner HRONIC ISCHEMIC Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying and -transit DISEASE law requires that the death certificate be executed Cause (Disease or iinjury that initiated events ORONARY Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE - nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23h. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Veal Yes 2 No signed by the a 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by SQUAMOUS CELL SKIN CANCER WITH 1 Yes 2 No 3 Probably 4 Unknown Records, ACUTE KIDNEY FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perforn or Attending Physician: The DIABETES Yes 2 No 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Hospital 1 ☐ Yes 2 ☑ No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funer work? 1 Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number D59418 APRIL 19, 2010 sawrenfur, us 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

O LUYEMIS i 31. Date filed (Month, Day, Year)

B. park

O. ADEWUNMI, MD.

32. Registrar's Signature

MONTGOMERY GENERAL HOSPITAL

AMEND#12 PER FH State of Maryland / Department of Health and Mental Hygiene For AVENUTIZED THE STATE AVENU Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Clayton Apri Davis 2010 1:30 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimure Washington Burnie Annie Medical Center JEN Arundel 7. Age (In yrs. last birthday) Social Security Numbe if Under 24 Hrs. Birthplace (State or Foreign Country) 8 Date of Birth **Funeral** (Month, Day, Feb. 27 409-44-9670 1 X M 2 □ F Min. Director labama Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any lajury or other traumatic event, the Medical Examiner must be notified at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Severna Park 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2 Brenda Court 21146 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 4 4 1968 If Yes, Give 7 1980 Year or Dates 1970 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1968 þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Completed Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Commercial Pilot U.S. Air Force 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Zama Meadows Horace Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irene A. Davis / Wife 2 Brenda Court Severna Park, MD 21146 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Aprilie 19, 1 Burial 2 X Cremation 3 Removal from State Metro Crematory, INC. Baltimore, MD 2010 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Rahrando & Soris, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Pa E ter the disease, or compligations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ock, o heart failure. List only one Imp ediate duse (Final disease or condition resulting in death) Pnysician/ ARte Dronam Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant a Month Pregnant at time of death 5 Other (specify) Day Year Yes 1 ☐ Yes 2 L 9 ☐ Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an nis certificate has I director, page 2 s autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 40 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 A Natural 5 Pending work? thin 24 hours after death.

the Funeral Director: Afortpleted filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie Hey novas 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Washington Medical Battimore 31. Date filed (Month, Day, Year) APR 2 0 2010 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ Frederick Bernard Davis 2010 9:50 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Kris-Leigh Assisted Living Severna Park Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Jan. 18, 1919 579-05-0506 Washington, Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director MD Anne Arundel Crofton 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2403 Falbrook Lane 21114 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give WWTT Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 3

Widowed 4 □ Divorced "natural" WWII Completed Year or Dates. permit. Page 1 and 2 should be filed within 72 hour popartment of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 th and Mental Hygiene.
7 is marked other than "i Elementary/Seconday (0-12) College (1-4 or 5+) 12 Firefighter Washington, D.C. Gov't Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Margaret Josephine Kohlman Percey Adwin Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 shument of Health auteurt: If item 27 is Robert F. Davis / son 2403 Falbrook Lane, Crofton, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 4/16/2010 Baltimore, MD Signature of Fundal Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Part 1. Enter the elsease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Approximate Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Division of Vital Records, 2 Du 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Jas autopsy perform death? 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural (Month, Day, Year) 5 Pending work 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗕 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29b. Signature nd title of certifie 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) 1041 VA

State Registrar

Darke

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 00 **Physician** AM Jack Hilton Dickens, Jr. LO /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert. Huntingtown 111 Amber Lane Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 01/16/1953 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 X M 2 □ F Director 57 Washington, DC 213-56-8422 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show ir than "natural", or items 23a or 28a-f shov 1 ☐ Yes 2 🖾 No MD Calvert Huntingtown Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20639 USA 111 Amber Lane Funeral Pages 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🗓 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 TNo Specify. Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) pormit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important; If item 27 is marked other the amy injury or other traumatic event, I'm ones. Fire Fighter P. G. County Fire Dept. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florence Marie Bailey Dickens Jack Hilton Dickens, Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Denise Dickens / Wife 111 Amber Lane, Huntingtown, MD 20639 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Waldorf, MD 4 ☐ Donation 5 ☐ Other (Specify) 04/26/2010 Trinity Mem. Gardens 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Signature of Funeral Service Lig Lisa Mounts 8125 Southern Maryland Blvd., Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ercinoma of /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.0. been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 s autopsy performed? Yes 2 No his certificate ha 25. Was case referred to medical Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural
2 Accident 5 Pending ours after death.

neral Director: Ai
filled in by the fu 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

dew 15

State

31. Date filed Month, Day,

Registrar

238 Merrimoc (

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Noble VI

32. Registrar Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar5-3-10Amend#2.PerPhys.PGCcr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 22. Physician/ Vera Evans 2010 9:58 a^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4146 Applegate Court Prince George's Suitland 5. Social Security Number 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. **Funeral** 1 🗆 M 2 🗔 🗜 Min. Hours 58 Director 113 44-7223 New . York 3/18/52 Usual Residence of Decedent ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 Q Yes 2 No Suitland MD Prince Georges 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 4146 Applegate Ct 20746 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Black, White, etc. 1 😾 Never Married 2 🗌 Married 1 Yes 2 No Completed by Saltimore, Maryland 21215-0036 1 ☐ Yes 2 x No Specify. 3 🗆 Widowed 4 🗆 Divorced Year or Dates Black 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within in Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Mental injury or other traumatic event, the Mental injury or other traumatic event, the Mental injury or other traumatic event, the Mental injury or other traumatic event, the Mental injury or other traumatic event, the Mental injury or other traumatic event, the Mental injury or other traumatic event injury or other event injur Elementary/Seconday (0-12) College (1-4 or 5+) Co-ordinator Medical Bed Control Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James H. Evans Lila Hickerson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eugene Henderson-Son 5708 Spruce Drive, Clinton, MD 20735 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Nassau Knolls Cem 4/27/10 Port Washington, NY 21. Signatur of Funeral Service Licenses 22. Name and Address of Facility Harvey"s Funeral Home Bushwick Ave., Brooklyn, N.Y 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a d be detached f g Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been signated by page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 🗆 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) Director: After this I in by the funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at work? 1 🗆 Yes 2 🗆 No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State 24 hours a Funeral I Medical 29a. Certifier 🗆 🗙 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. . Dav. Year

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DHMH 17 Rev 7/2009

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30. Name and address of b

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rson who completed cause &

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 🤈 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ UBERT Month [[] M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 488 Williamsburg Lane Odenton Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours M 2 D F 2/11/1927 Director 009-12-8302 83 Usual Residence of Decedent 3a or 28a-f show t be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director MD Anne Arundel Odenton 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 488 Williamsburg Lane **Examiner must** 21113 USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces' 1 Yes 2 If Yes, Give Black, White, etc. ^{2 No} 44-46 0 þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. Decedent's Education 16a, Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) Printer use retired) Elementary/Seconday (0-12) College (1-4 or 5+) G.P.O. 08 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Luther Eley Marion Wilkens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor Eley Spouse 488 Williamsburg Lane Odenton,MD 21113 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal from State Atlantic Crematory 4/19/2010 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie,MD 21. Signature of Funeral Service License 22. Name and Address of Facility vala Hardesty Funeral Home P.A. 23a. Part 1. Enter the disease, or complications that caused the heath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician. disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for 5 Other (specify) Month Day Year Pregnant at time of death detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 2 🗆 No 1 Tes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 10 Hospital: 2. No Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🖅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gertifying Nurse Practioner To the best of my knowledge, death consend at the time, determined at the

30. Name and address of person who concluded cause of death (Item 23a) (Type, Print)

State
Registrar

APR 2 1 2010

Registrar's Signature

APR 2 1 2010

Authorized the time defered place and direct to the product of

Physicia Medic Examin Funeral Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 Physician/ Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760 6 Stat

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n/ al	1. Decedent's Name <i>(First, Middle, Last)</i> <u>Carolyn Marie Fra</u>	dy				2. Date of De Month April		2010	3. Time of Death 6:35 PM		
er .	4a. Facility Name (if not institution, give street and number)	TT	24.7	4b. City, Town, or			4c. County of Death Frederick				
		ge (In yrs. la	e (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth						Birthplace (State or Foreign		
	229-66-2694	62	Yrs.	Months Days	Hours Min	Sept. 2	3, 1947	1947 New York			
ctor	10a. State 10b. County		y, Town or Loc					1	0d. Inside City Limits		
Dire	Maryland Carroll 10e. Street and Number	Mo	ount A	iry 10f. Zip Code			10g. Citizen of	What Cour	1 X Yes 2 □ No		
neral	507 Lewis Court		21771 Ur								
Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates.		l II	Vas Decedent of His Yes, specify Cubar ☐ Yes 2 🛣 No	, Mexican, Puer	Specify Yes or No- to Rican, etc.)	Bla	ce - Americ ack, White, y: Whit	etc.		
mplet	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or	5.1	(Give k	ent's Usual Occupa sind of work done do NOT use retired)		orking	16b. Kind of E	Business Inc	dustry		
e Co	2	5+)	Truck	Owner/Op			Transp		ion		
10 B	17. Father's Name (First, Middle, Last) Logan J. Purcell	ne)									
	19a. Informant's Name/Relationship (Type, Print) Joseph R. Frady, Jr. / Hust	pand	19b. Mailin 507 Lo	g Address (Street a. ewis Cour	nd Number or R t, Mt.	ural Route Numbe Airy, MD	er, City or Town, 21771	State, Zip (Code)		
	20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. P	lace of Disposemetery, crem Restha	sition (Name of natory or other place axen Gardens	Apr	il 23,	20c. Location				
Memorial Gardens 2010 Frederick, Maryland 21. Signature of Funcial Service Licensee Restliaven Funcial Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701											
	23a. Part 1 Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lin Immediate Cause (Final disease or condition resulting in death)	e St	n. Do not ente						Approximate Interval Between Onset and Death		
al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):										
Medic	IF FEMALE:										
Be Completed by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal	Ideath 3 🗌	Ectopic pregnancy Other (specify)				ate of delive onth	ery Day Year		
d by P	Part II. Other significant conditions contributing to death b	out not resu	ulting in the ur	nderlying cause give	en in Part I.				e cause of death?		
mplete						24a. Was auto	osy	Were autor prior to cor death?	osy findings available npletion of cause of		
င္တဲ့ မြ	25. Was case referred to medical examiner?			26. Pla	ce of Death (Che	1 Tes	2 X No	1 Yes	2 🗌 No		
	1 ☐ Yes 2 No Hospital:		ER/Outpatien		4 ☐ Nursing	Home 5 Resid					
cate	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		28b. Time of injury	28c. Injury work? M 1 🔲 Y	at ′es 2 □ No	28d. Describe h	ow injury occuri	red			
3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number of Street and Num											
Medical Certificate: To	29a. Certifier (Check only one) 3 Certifying Physician: To the best of conly one) 3 Certifying Nurse Practioner: To the	examination	and/or investi	gation, in my opinion	, death occurred	at the time, date a	nd place, and du	e to the cau	ise(s) and manner stated.		
	29b. Signature and title of certifier			29c. License MDD 6	number		29d. Date signe	ed (Month, L			
Ì	30. Name and address of person who completed cause of d Ghulam Abbas, M.D. 400 Wes				rick, M	D 21701					
9	31. Date filed (Month, Day, Year) APR 2 2 20 0	ar's Signatu	ure 🥻	backer							
r	APR & & ZU U JAC	and the same of the same of the same of	100	/				-			

Registra

			1 - State Registrar		Ce	rtificate of	Death		Reg. No.	10	4434
	Physic	an	1. Decedent's Name (First, Middle, Las	0 1 00	C.11		-0	2. Date of Dea	ath Day	Year	3. Time of Death
	/Medi	cal	An English Name //f not institution air	Flunaic		Ah City Tayur	v Langtion of Dooth	4	19	2010 nty of Death	130 L W
q	Examii	ner	4a. Facility Name (If not institution, give 765 Taliaferro Rd	,			r Location of Death napolis			ne Aru	ındel
	Funeral Director		311 20 3992	ex 7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 2/6/19	th ly, <i>Year)</i> 922	Cour	place (State or Foreigntry) ington, DC
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				1	0d. Inside City Limits
	Mary a-f sh	tor	Maryland Anne Ar	undel An	napoli	S					1 □Yes 2 No
	or 28	Direc	10e. Street and Number		<u>-</u>	10f. Zip Code			10g. Citizen	of What Cour	itry?
	ath wi	rall	765 Taliaferro Rd			21403			USA		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the "Marked Expression must be notified at once.	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: 1944~		Was Decedent of H If Yes, specify Cub 1 □ Yes 2 \times No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	- 14. F E Spe	Race - Americ Black, White, c cify: Whi	etc.
5-0	72 ho 'natur	etec	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Dece	dent's Usual Occup	pation during most of work d)	ina i	16b. Kind of	Business/Ind	dustry
121	vithin ene. than "	dm	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire ems Engin			Aoro	anaca.	
d 2	filed v Hygie other i	ပ္မ	17. Father's Name (First, Middle, Last)	4 years	Syst	ems Engli	18. Mother's Name	e (First, Middle,		space	
Maryland	ild be fental rked c	To Be	Richard Joseph	Fullam			Mar	ie Grif	fith		
ary	2 shou and M is mai	-	19a. Informant's Name/Relationship (7	ype. Print)	19b. Maili	ng Address (Street	and Number or Rur	al Route Numbe	er, City or Tov	vn, State, Zip	Code)
₹,	and 2 ealth n 27 i		Patricia H. Fulla	`			o Rd., An				
Baltimore,	permit. Pages 1 Department of H Important: If iter any injury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify) MD	Veter		ery 4/26	/10		n-City or To sville	
Ball	Departition of the poor in the		21. Signature of June al Service Licens	see		2. Name and Addre	00				al Home
	402 % 0		23a Part 1 Entar the disease or come	ligations that caused the deat			omons Isla			ter, M	
	Physician /Medical Examiner	resulting in death) a. Due to (or as a consequence of):									Approximate Interval Between Onset and Death
68760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t							
P.O. Box 6	the death certifi by the attending I ached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o 9 ☐ Unknown	al death 3 [⊒ Ectopic pregnand ⊒ Other <i>(specify)</i> _	су			Date of delive	ery Day Year
	uires that the de n signed by the a ld be detached i		Part II. Other significant conditions co	entributing to death but not res	ulting in the u	nderlying cause giv	ven în Part I.	23e. Did to			he cause of death? pably 4 ☐ Unknowr
of Vital Records,	lan: The law requir rrificate has been s tor, page 2 should	Completed by								b. Were auto prior to co death? 1 ☐ Yes	psy findings available mpletion of cause of 2 No
Vita	siclan; certific rector,	Be (25. Was case referred to medical examiner?	Unonital		100	26. Place of Deat	h (Check only o	ne)		
of	Physical direction	은	1 ☐ Yes 2 1 No 27. Manger of Death	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatie	nt 3 L DOA	ner: 4 ☐ Nursing Ho	me 5 Residence 1		. , ,	y)
	fing Affe fune	ation	1 Natural 5 □ Pending 2 □ Accident investigation	(Month, Day, Year)	Injury	Wor	k? lYes 2 □ No	Zou. Describe i	low injury occ	uneu	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, sti	reet, factory, office		28f. Location (5 City or Tov	Street and Nu vn, State)	mber or Rura	al Route Number,
	To the Hospital of within 24 hours at To the Funeral D completely filled it	cal	(Check only 2 edical Exam	rsician: To the best of my kno iner: On the basis of examina and manner stated.	ation and/or in	vestigation in my	oninion, death occur	red at the time	date and place	e and due to	n the cause(s)
	Vith COT	Σ	29b. Signature and title of certifier 30. Name and address of pers in y o c 31. Date filed (Month, Day, Year) APR 2 2 2	WD		29c. Licens	o 00643	79	29d. Date sig	ined (Month, 2010	Day, Year)
74	+7+1		30. Name and address of pers in who c	ompleted cause of death (Iter	m 23a) (Type,	Print) Jay	Uper 9	o lests.	Le Rd	Suk 3	100 Anapolis
	Sta Registi	te ar	APR 2 2 2	2010 32. Registrar's Signa	A	bake					, , , , ,

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Registrar

P.O. Box 68760,

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April Dorothy Ferrario Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Skyway Manor Assisted Living Annapolis 5. Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** ^{Year)}1<u>927</u> 189-20-0791 1 □ M 2 🛛 F Davs Hours 82 **Director** June Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 931 Edgewood Road Funeral 21403 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 XXVo þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: If Yes, Give 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Seamstress 12 Dress Factory Be 18. Mother's Name (First, Middle, Maiden Surname)
Nellie Yadlosky 17. Father's Name (First, Middle, Last) ည Peter Nestor 19a. Informant's Name/Relationship (Type, Print)

John Ferrario/husband 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
931 Edgewood Road Annapolis, Maryland 21403 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or oti cemetery, crematory or other place)
Catherine's Cem. 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State St. 4/24/2010 Moscow, Pennsylvania 4 Donation 5 Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home Signature of Funeral Service Licensee 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ SSNI/E disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Live Beath 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown signed by the a d be detached for 1 ☐ Yes ≥ E P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, Completed peen 24a. Was an Hospital or Attending Physician: The law 124 hours after death.
Funeral Director: After this certificate has k ated filled in by the funeral director, page 2 s autopsy performed Yes 2 this certificate has al director, page 2 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be 2 🗹 No Hospital Other: 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: injury work?
1 Yes 2 No Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation in 24 hou... the Funeral Dire... 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the F only one) 29b. Signature and title of certifie 29c. License number *ଇ* ଅଟେଟ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brileus. S1. Date filed (Month, Day, Year) Swith DUL SAMMS 2835 State

Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No AssisTEL 4 Nursing Home 5 Residence 6 Other (Specify LIVING 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d, Date signed (Month, Dav. Year) **ORIGINAL**

3. Time of Death

12:15 P M

2010

U.S.A.

Black, White, etc.

Anne Arundel

White

9. Birthplace (State or Foreign

Pennsylvania

10d. Inside City Limits

1 X Yes 2 No

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Physician Month Franks James April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** talbet ston 8. Date of Birth (Month, Day, Year) If IJnder 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 213-60-9541 100 M 2□ F Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director Talbot Easton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. be filed within 72 hours after on tal Hygiene. 1 Yes 2 If Yes, Give Year or Dates; 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify ò 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Security 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Mae Franks Jack son ၉ dna 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health Easton Important: If item 27 any injury or other tr Maryland M. Thomas 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Cemetery Esther 4/24/10 Easton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of acility 21. Signature of Funeral Service Licensee Home, P. A. Funeral sio washington St. Cambridge, MD. 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardionyo **Physician** 4ears disease or condition resulting in death) /Medical Due to (or as a consequence of). **Examiner** Misens Yens Coronny Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Hyperlensin 4eas that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Year Month 5 Other (specify) signed by the a □Yes 2□No Ö 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy performed certificate 1 ☐ Yes 2 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 € No 1 ☐ Yes 2 ER/Outpatient 3 DOA 1 Inpatient within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DO05225 Physician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) chesa feake 830

Registrar DHMH 17 Rev 1/2001

State

1 Uhammad

10-03064 Louise A. Frost

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Cen	tificate of	Death		, ,	Re	g. No. 20	10	14436
Physicia ledical Examii		Decedent's Name (First, Middle, Louise Anna Vann Fro					Date of Deat Month April 19, 2	Day Year 010		3. Time of Death 2004 hrs		
		4a. Facility Name (if not institution, of Calvert Memorial	give street and number)			4b. City, Town, Prince Fro		of Death		4c. County o	f Death	
Funeral Director		E70 20 61/2	Sex 7. Age M 2XF	e (In yrs. Ia 88	st birthday) Yrs		ear If Unde ays Hours		3. Date of Birt 08/08/	h(MM/ DD/YYYY) 1921	Foreig	
daryland 28a-f show any Latonce.	٦٢	Usual Residence of Decedent 10a. State 10b. County MD Calvert		10c. City, Dunki	Town or Locati	on						10d. Inside City Limits 1 Yes 2 X No
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 1459 Knight Avenue				10f. Zip Code 20754			10	g. Citizen of Wh USA	at Coun	ntry?
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shunatic event, the Medical Examiner must be notified at once	by Funeral		1 Yes 2 led If Yes, Give Year or Dates:	X No	1f Y	s Decedent of es, specify Cub Yes 2 X	an, Mexican	, Puerto Rio	can, etc.)	White Specify:	, etc. Whit	
5-0036 led within 72 hours Hygiene. other than "natur	ompleted	15. Decedent's Education (Specify Elementary/Secondary (0-12)	only highest grade com College (1-4 or 5		during m	t's Usual Occup ost of working I Operator	fe. DO NOT	use retired)		ling/	Publishing
21215-0036 Juld be filed within 7: Mental Hygiene. marked other than c event, the Medical	Be C	17. Father's Name (First, Middle, La Edward Franklin Vani	n				Laura	Melve	nia Maud			
s, MD 2121 and 2 should be fi feath and Mental I tem 27 is marked traumatic event,	2	19a. Informant's Name/Relationship Gifford E. Frost, J.			1459 I	Knight Av	enue, I)unkirk	, MD 207			
imore Pages 1 ment of F		20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other Speci	fy:	te cr	rematory or oth Lincoln	Cemeter	у	04/24/		Brentwo	od, N	MD D
		21. Signature of Funeral Service Lic	1		812		rn Mary	land B	lvd., O	Home Calv vings, MD	2073	6
Physician /Medical Examiner		23a. Part I. Enter the disease, or confailure. List only one cause on Immediate Cause (Final disease or condition resulting in death)		Hemorrl	hage	ne mode of dylr	g, such as c	ardiac or re	spiratory arre	st, snock, or nea	п	Approximate Interval Between Onset and Death
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	quence of)	:						_	
cuted and transit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of)	•			-				
e exe	Medical	UNPENDED [AMENDED							Lead Baller		
Box 68760, a death certificate by the attending physic ed for use as the burnel	sician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknow	23c. If yes, outcom 1 Live birth 4 Pregnant at t 9 Unknown		2 Fet	al death (Ectopic	pregnancy		23d. Date of o	-	ay Year
P.O. B	by Phy	Part II. Other significant conditions	contributing to death	but not res	sulting in the u	nderlying cause	given in Pa	rt I.	1			he cause of death?
of Vital Records, P.O. Box 68: ng Physician: The law requires that the death certificate has been signed by the attending meral director, page 2 should be detached for use as in	Completed								24a. Was a autops perforr	y pr ned? de		opsy findings available ompletion of cause of s 2 No
ital Reician: The scertificate rector, page	Be	25. Was case referred to medical examiner?	Hospital; 1 / Inpatier	<u> </u>	- D/O: to ation t		Other				lon	
of V g Phys fter this	잂	1 ✓ Yes 2 No 27. Manner of Death	2Ba. Date of Injur	у 1:	R/Outpatient 28b. Time of In		jury at Work			Residence 6		
Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifiely filled in by the funeral director.	Certification:	1 Natural 5 Pending 2 Accident Investiga	ation		ne farm stree		Yes 2		Location (St	reet and Number	r or Pur	al Route Number, City
Divis spital or At nours after d neral Direc	Certif	3 Suicide 6 Could no determin	ot be			t, idotory, omo	Danoing, ox		or Town, St		Of Itali	arroade Namber, Orly
To the Hos within 24 h To the Fur completely	edical	one) 2 Medical Examin	cian: To the best of my er:On the basis of exam and manner stated.									
	Ž	29b. Signature and title of certifier	1000				.M.E.			29d Date signed April 20, 20		th, Day, Year)
1 km 10		30. Name and address of person who Donna M. Vincenti, MD	Assistant Medica			Penn Stree	et, Baltimo	ore, MD 2	21201			
Sta Registi	ite rar	31. Date filed (Month, Day Year)	2010 32. Registrar		A. Soa	Wed				<u> </u>		

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure Al	Il Copies Are Legible.	0 13 1 0
State of Maryland / Department of Health and M	lental Hygiene 201	0 1443
Certificate of Death	Reg. No.	
	2 Date of Dooth	1.2 Time of Death

		1- For State Registrar	Cen	tifica	te of Dea	ath		,,,	Reg.	No.	. •	
Physicia	n/	Decedent's Name (First, Middle,Last)							Date of Death Month D	ay Yea		3. Time of Death 1021 hrs
Medical Examin		Gary Lee Fillma 4a. Facility Name (if not institution, give street and nur			4b City	v Town o	r Location of De		pril 18, 201	4c. County o	f Death	1021 1115
		25 Moutain Trail	ilber)			nce Fre				Calvert		
Funeral		Social Security Number 6. Sex	7. Age (In yrs. Ia	st birtho		nder 1 Ye		_	Date of Birth(MM/DD/YYYY)		nplace (State or
Director		219-54-5585 1XM 2DF	59		Yrs, Moi	nths Da	ys Hours N	/lin.	07-16-	1950	Foreigr Cou	intry) Wash., DC
>	ļ	Usual Residence of Decedent										40.1.1.1.1.0.2.1.1.2.2
w any		10a. State 10b. County	10c. City,	I own or							ŀ	10d. Inside City Limits 1 Yes 2 X No
Maryland 28a-f show 1 at once.	MD Calvert 10e. Street and Number				nce b Zip Code	rederic	K	1100	Citizen of Wh	at Coun		
th the Maryland 23a or 28a-f sho notified at once	Director				101. 2	2067	70		l log.	USA	at oour	
0036 within 72 hours after death with the Maryland giene. her than "natural", or items 23a or 28a-f she Medical Examiner must be notified at once	핕	25 Mountain Trail 11. Marital Status 12. Was Dece	edent Ever in U.S	S.	13. Was Dece		ispanic Origin? (Specif	y Yes or No-		- Americ	an Indian, Black,
death v	uneral	1 Never Married 2 X Married Armed Fo		- 1	If Yes, spe	cify Cuba	n, Mexican, Pue	rto Rica	an, etc.)	White	, etc.	
after o	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1970-74				o specify:			Specify:		ite
hours natur Exam	g	15. Decedent's Education (Specify only highest grad					ation (Give kind on e. DO NOT use r		done 16	6b. Kind of Bus	siness/Ir	ndustry
5-0036 led within 72 hou Hygiene. other than "nat	Completed	Elementary/Secondary (0-12) College (1-	4 or 5+)	Fi	ro Saf	etv]	Inspecto	r		MD Stat	-e F	ire Marshal
d with	팅	17. Father's Name (First, Middle, Last)		11	ic bar		18.Mother's Na					TIC Harbina
	e l	George F:	illmann				Dorot	hy			Sti	ine
21 hould nd Me is man	의	19a. Informant's Name/Relationship (Type, Print)					et and Number of					
e, MD t and 2 sho Health and item 27 is	-	Donna Lynn Fillmann, spo 20a. Method of Disposition			5 Moun Disposition (N		Trail,			Oc. Location -		
트 플 프 프 필		1 X Burial 2 Cremation 3 Removal fro	m State C	remator	y or other pla	ce)	= "				•	,
ti. Pag tr. Pag trant:	-	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Che	sape	22, Name a		nds 04					
Baltimo permit Page Department o Important: injury or oth	J	MI Dicass B. CA	_				Harmony		sch Fun e. Owir)736
Physician	1	23a. Part I. Enter the disease, or complications that ca	used the death.	Do not								Approximate Interval Between Onset and
Examiner	1	failure. List only one cause on each line. Immediate Cause (Final disease a, Hypertensiv	erotic (tic Cardiovascular Disease Death								
. LXaIIIIICI	-	or condition resulting in death) Due to (or as a	consequence of):								
	<u>ا</u> ه	Sequentially list conditions, if any, leading to immediate b. Due to (or as a	consequence of):								
	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated										
ted I Insit	E	events resulting in death) Last Due to (or as a d.	consequence of):								
760, icate be executed physician and the burial - transit	힐	UNPENDED AMENDED										
760, cate be physic	Medical	IF FEMALE: 23c. If yes, o	utcome of pregn	ancy						23d. Date of	delivery	
OX 687 ath certific attending properties as the	- 1	23b. Was decedent pregnant in the past 12 months?	rth ant at time of dea	2 [Fetal dea		Ectopic preg	gnancy		Month	D	ay Year
Box 687 e death certifi the attending ed for use as t	Physician	1 Yes 2 No 9 Unknown 9 Unknown		atn 5	Other (S	pecify)				11		
O. B. at the de at the de tached t		Part II. Other significant conditions contributing to	death but not re	sulting i	n the underly	ing cause	given in Part I.		23e. Did toba	cco use contrit	oute to t	he cause of death?
rres that to signed by I be detac	Completed by	Lung disease						_	1 Yes	2 No 3	Proba	abiy 4 🗸 Unknown
ords v requ s been	<u>ş</u>							_	24a. Was an autopsy			opsy findings available ompletion of cause of
Reco The law cate has	E								performe		eath? ✔ Yes	2 No
tal Recian: The certificate	Be C	25. Was case referred to medical examiner?				26.Plac	e of Death (Che					
Division of Vital Records, tal or Attending Physician: The law requirers after death. The birector: After this certificate has been sited in by the funeral director, page 2 should be a burner and the funeral director.	٥	1 ✓ Yes 2 No			ne of Injury	DOA lair	Other Nur			sidence 6		Scene
ion of tending Ph eath. tor: After the funeral	삥	27. Manner of Death 1 Natural 5 Pending 28a. Date of (Month,	Day,Year)	200. H	ne or injury		Yes 2 No	200	l. Describe how	rinjury occurre	łū	
ivision or Atten after death Director:	<u>icati</u>	2 Accident Investigation 28e. Place	of Injury - At ho	me, farn	n, street, facto			28f.	Location (Stre	et and Numbe	r or Rur	at Route Number, City
Divisipital or At ours after dours after direct filled in by	Certification:	Suicide 6 Could not be determined (Specify)				•			or Town, State	9)		
Hosp 24 hou Fune stely fi		29a. Certifier 1 Certifying Physician: To the best	of my knowledg	e, death	occurred at	the time, o	date and place, a	nd due	to the cause(s	and manner	as state	d.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Puneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mann one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mann one) 2 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mann one) 2 2 Substitute and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date signature											
	Σ	29b. Signature and title of certifier		29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 19, 2010							th, Day, Year)	
		Carol Halla	11	••		0.0	.IVI. C.			April 19, 20	10	
2W 15+1		 Name and address of person who completed cause Carol Allan, MD Assistant Medical E 			enn Street	t, Baltim	nore, MD 212	201				
Sta	ite		istrar's Signatur				,					
Registi		APR 2.2.2010 /2	and I	9	backs	1						

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Carol Luceal Blackwell Fitzgerald 3:30 P Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Anne Arundel Examiner 4b. City, Town, or Location of Death Chesapeake Hospice House Harwood 5. Social Security Number if Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday) Hours 1 □ M 2 🗶 F Days Months 230-58-9068 65 Director Yrs. 05/12/1944 Usual Residence of Decedent 3a or 28a-f show t be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Suitland 1 XYes 2 ☐ No MD Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral **AZU** 20746 3901 Suitland Rd. Apt. 403 the Medical Examiner must and Mental Hygiene. is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian Black, White, etc. δ 1 Never Married 2 Married ☐ Yes 2 No 1 ☐ Yes 2 XNo Specify: If Yes, Give Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Dept. of Transportation Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname မ Louise Marie Harris Allen Matthew Blackwell, Jr. permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michele Lee Fitzgerald/daughter|ጔጔዛጔጔ Lake Arbor Way Apt.8ጔ?¬ Mitchelleville¬MD2O?2ጔ 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Marmony Memorial Cem. 04/23/2010 Landover MD Signature of Funeral Sen 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd., Camp Springs, MD20748 Par T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Meningeal Carcinomatosis disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 6 wks Adenocarcinoma Lung Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): and Il-transit Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a s the burial-Physician/Medical attending p IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Year Day signed by the a g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page perform 1 Yes s after death.

I Director: After this certifica ed in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes 2 No 1 X Natural injury 5 Pending M Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) 04/19/2010 D13778 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas Tesoriero 2100 W. Pennsylvnia Ave. NW Washington D.C. 20037 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

APR 2 7 2010

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar amend 5-22 per hosp. 24 per Prificate 1903 Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year 2010 5 /Medical 4a. Facility Name (If not institution, give street and number) Examiner City, Town, or Location of Death 4c. County of Death BATTMORE MERLY MEDICAL 9. Birthplace (State or Foreign Country)
MD • 5. Social Security Numbe If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 1/15/10 7. Age (In yrs. last birthday) **Funeral** Year) Days 1 ☐ M 2 ☐ F Hours 20 Yrs **Director** Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f show MD **Baltimore** Baltimore Director 1 ☐ Yes 2 TANo 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? by Funeral 202 Fox Haven Court death 21136 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Asian 1 ☐ Yes 2 No 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medic once. Elementary/Secondary (0-12) College (1-4or 5+) Infant Infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Farakh Mahmood Umme Farwa 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Umme Farwa (mother) 202 Fox Haven Court 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 🗫Other (Specify) Sur. Path Mercy Med. Center 1/15/10 Baltimore, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lisa Logan M.D. (per DVR) Mercy Medical Center 301 ST. Paul St. 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PREMATURIA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed and Due to (or as a consequence of) P.O. Box 68760 attending physician Physician/Medical the use yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy õ in the past 12 months? Year Pregnant at time of death 5 Other (specify) □Yes 2□No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2√No Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy Hospital or Attending Physician: The performed? Yes 2 No certificate 1 □ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 □Yes 2 □No 2 Accident 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To th, within 24 (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature, d title ef-certifie 29c. License number 29d. Date signed (Month, Day, Year) 03 20/0 D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Met PAVIS Day, Registrar's Signa

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#20a-c. perFH. G903.5/14/2010 WS State of Maryland / Department of Health and Mental Hygiene State
Registra Amend#23b. PerPhys. PGC4-28-10 Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3, Time of Death Physician/ Month Year LEWIS GIBSON JR 2010 10:15 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SOUTHERN MARYLAND HOSPITAL PRINCE GEORGES CLINTON 8. Date of Birth (Month, Day, Year) 12–19–1942 Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours 67 Director **GEORGIA** 2<u>5</u>2-64-9424 Usual Residence of Deceden "natural", or items 23a or 28a-f show 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 No MD PRINCE GEORGES DISTRICT HEIGHTS 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral UNITED STATES 2715 JUDITH AVENUE 20747 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2X No Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2X No Specify: Yes. Give 3 Widowed 4 Divorced Completed Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) TILE SETTER SELF EMPLOYED Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည LEWIS GIBSON SR. ANNIE PEARL NEAL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 909 BERWICK DR. ANNAPOLIS MD 21403 GARRICK GIBSON/ SON permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State
Brentwood, Maryland
ANNANDALE, VIRGINIA Date Ft. college College Cory 1 XBurial 2 Cremation 3 Removal from ANNANDALE, 4/30/2010 4 Donation 5 Other (Specify) 21. Signature Juneral Service L 22. Name and Address of Facility JOHN T. RHINES FUNERAL HOME. LLC 3005 12th ST. NE WASHINGTON, DC 20017 art 1. Enter the disease, or complications that caused hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition Physician/ Praumoria a Serostion Medical resulting in death) Due to (or as a consequ Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: Live Birth 2 Fetal death 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year I signed by the a Yes -9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Careborovas cular Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 sl autopsy certificate h performed 1 ☐ Yes 2 ☐ No ☐ Yes 2 Be 25. Was case referred to medical director, 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ Inpatient 2 ER/Outpatient 3 DOA After this Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28a 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural 1 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Contifying Nurse Practioner To the best of my knowledge, doesn convenid at the time, date and place, and due to the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year, State APR 2 6 2010

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle Last) 2. Date of Death Month 04 **Physician** RENE 2010 312 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Arnold 77 Beckett Court 8. Date of Birth (Month, Day, Oct. 22, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** ^{Year)} 1959 Months Days Hours Min. 1 M 2 □ F Germany 50 Director 051-56-7496 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-1 shov traumatic event, the Medical Examinar must be notified at MD Anne Arundel Arnold 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21012 USA 77 Beckett Court Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1979 14. Bace - American Indian. 11. Marital Status Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give
Year or Dates: Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1999 altimore, Maryland 21215-0036 White 1 ☐ Yes 2 🕱 No Specify. Specify. \$ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Naval Academy Research Director 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bobby Gene Gregory, Sr. Alice Abrahamian မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Courtney K. Parfitt/Daughter 1410 Greendale Court Arnold, MD 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition April 19, 1 ☐ Burial 2 🔀 Cremation 3 PRen oval from State Metro Crematory Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 2010 Signatur of Funeral S 22. Name and Address of Facility Barranco & Sons rvio P.A. Severna Park Funeral Home Prt . Enter the disease, or shock, or heart failure. List 495 Gov. Ritchie Hwy. Severna Park, MD 21146 uni Approximate Interval Between Onset and Death blications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediate Lause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed burial-tran and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a P.O. 1 □Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown icate has been siç r, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performe The 1 ☐ Yes 2 1 No Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2/1 No 1∐ Yes 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated.

State Registrar

APR 2 0 2010

ne and address of person who completed cause of death (Item 23a) (Type, Print)

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22. Registrar's Signature
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1^D2^y 2010^{ear} APRIL **GIBBONS** 7:29 A M ELLA Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL CLINTON Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min oct. 23 1 □ M 2√2 **Director** 137-22-5518 83 1926 MARYLAND Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Ves 2 No PRINCE GEORGE'S MD LANDOVER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 7008 KENTTOWN DRIVE 20785 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? 1 ☐ Yes 2 X No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: BLACK If Yes, Give 3 XWidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 4YRS REGISTERED NURSE PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည TIGHMAN E. JACOBS ERMA A. JACOBS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7008 KENTTOWN DRIVE, LANDOVER, MARYLAND MARILYNNE A. BROWN/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MEADOWRIDGE CEMETERY: 4/23/2010 ELKRIDGE, MARYLAND Signature of Funeral Service Licensee J. B.JENKINS FUNERAL HOME 22. Name and Address of Facility 10 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ De disease or condition resulting in death) S Medical Due to (or as consequence of): Deho distion Examiner R MIL Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury per mutemi Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death 5 Other (specify) Yes 1 ☐ Yes 2 L 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No ∕3 ☐ Probably 4 ☐ Unknown 4b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe 1 Yes 2 XNo 25. Was case referred to edical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 2 11/10 မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes Certificate: 28b. Time of 28d. Describe how injury occurred Natural injury 5 Pending 2 🗌 No Accident Investigation Accider
Suicide within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 10 04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day, State

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Registrar

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DHMH 17 Rev 1/2001

State Registrar 6900

31. Date filed (Month

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Charles Ernest Hickman 2010 Medical 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** County of Death 5 61 Comico 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) (Month, Day, Year -22-1924 1 🕅 M 2 🗆 F Director 85 220-12-0518 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2705 Old Ocean City Road 21804 USA 12. Was Decedent Ever in U.S.

Armed Forces?

1 X Yes 2 □ No 1943If Yes, Give
Year or Dates. 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Completed by 1 ☐ Yes 2 🔀 No Specify: White 3 Widowed 4 Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Truck Driver 0il Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Herman Woodrow Hickman Mattie Virginia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Hickman - Wife 2705 Old Ocean City Road, Salisbury, Maryland 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4-24-2010 | Salisbury, Maryland 4 Donation 5 Other (Specify) Wicomico Memorial Pk. Signature of Funeral Service Licenses 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ARDIOMYOPA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant a 9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) sate has been signed by the a page 2 should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 K No Other: 4 Nursing Home 5 Residence 6 Hother (Specify) HOSPICIZ မြ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of Certificate: 28c. Injury at w<u>ork</u>? Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 24 hours after deat 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29c. License number amp 20058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IVA

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Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Year April 14, 2010 Emeterio Rubi Hernandez 2:15 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3139 Beltsville Road Beltsville Prince Georges Months Days Hours Min. B. Date of Birth Month, Day, Year 948 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1⊠M 2□F EÎ Salvador 62 097-92-4497 Yrs. Director Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow the Medical Examiner must be notified at 1 XYes 2 No Director Maryland Prince Georges Beltsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3139 Beltsville Road 20705 El Salvador items 23a Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 ☐ Yes 21 No If Yes, Give Year or Dates: 1K Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ö Mary Yes 2□ No Specify: Salvadoran Specify: Hispanic þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Walter Reed Hospital 9th Pages 1 and 2 should be filed v riment of Health and Mental Hygie rtent: if item 27 ie marked other t jury or other traumatic event, II! 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Osvaldo Rubi Sipriana Hernandez 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2213 Apache Street Hyattsville, Md. 20783 19a. Informant's Name/Relationship (Type, Print) 2213 Apache Street Yesenia E. Ramirez Rubi (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: if ite eny injury or ott once. 1 ☐Burial 2 ☐ Cremation 3 Removal from State 04/26/2010 El Salvador Family Cemetery 4 □ Donation 5 □ Other (Specify) 21. Signafur Juneral Service W. H. Bacon Funeral Home, 3447 14th Street, NW Inc. Washington, DC 20010 Part 1 ver interpresease, or complications sho k, or heart ailure. List only one cau tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death Imm viate Cause Final dise is a or condition resulting in death) Myocardial Infarction **Physician** /Medical Due to (or as a consequence of): Examiner Myocardial Ischemia Sa uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed physiclen and s the burial-transit and r resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown s been signed to should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Tes 1 Yes 2 X No 2 K No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home \$ Residence 6 Other (Specify) ဥ 1

Yes 2 □ No 3□ DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: / 6 □Cou I not be 3 Suicida To the Hospiter c. . within 24 hours atter d To the Funeral Direc Place of Ir jury - At-home, farm, street, factory, office building, etc. (Special) Location (Street and Number or Rural Route Number, City or Town, State) 4 H Himicide 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Ignature and title of certile 29c. License number 29d. Date signed (Month, Day, Year) MD32507 April 21, 2010

Division of Vital Records, P.O. Box 68760,

State Registrar 31. Date filed (Month, Day, Year) 2010

3 Name and address of person will

Rosemarie A. Rollins-Folks, M.D.

mpleted suse of death (tell 23a) (Type, Print)

8709 Flower Ave., Silver Spring, Md. 20901

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ APRIL JUANITA E. 20°, 2010° HUEHN 7:45 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NATIONAL LUTHERAN HOME MONTGOMERY ROCKVILLE 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F Months Days Hours Min. oct. 25, 1913 305-10-4272 INDTANA 96 Director Usual Residence of Decedent I Hygiene. I other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD. MONTGOMERY ROCKVILLE 1X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9701 VEIRS DRIVE 20850 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc ģ 1 Never Married 2 Married Specify: WHITE Maryland 21215-0036 1 ☐ Yes 2X No Specify: Yes. Give 3 ₩ Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired)
HOMEMAKER Elementary/Seconday (0-12) College (1-4 or 5+) AT HOME 12 Be other traumatic event, 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental Himportant: If item 27 is marked any injury or cate. 18. Mother's Name (First, Middle, Maiden Surname) is marked or FORBE YAW MARIE MUIR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

RAT.TTMORE, MD. #602 19a. Informant's Name/Relationship (Type, Print) COLETTE STEINMEIER -NIECE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State METROPOLITAN CREM 4/21/2010 1 🗆 Burial 2 ី Cremation 3 🗀 Removal from State ALEXANDRIA, 4 Donation 5 Other (Specify) 22. Name and Address of Facility 222-WISCONSIN AVE., NW Signature of Funeral Service Licenses ellen HYSONG CO. WASHINGTON 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician ARDIAL disease or condition resulting in death) 45RRHYTHOLD Medical Due to (or as a consequence of) Examine HYPERTENSIO Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) burial-transit attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 5 Other (specify) signed by the ard be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy Director: After this certificate I 1 Yes 2 No ☐ Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital Other: မ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Getting in Notice and the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

31. Date filed (Month, Day, Year) APR 2 3 2010

29b. Signature and title of certifie

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(Check only one)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DO5 115

ROCKVILLE

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra4-23-10Amend#2.PerPhys.PGCcc Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month April Physician/ 0514 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death thesp m MUNTGOMER ADVENTIT WAITHOUN Micana 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 26) 9. Birthplace (State or Foreign Funeral 1 X M 2 □ F Months Days Hours Min. North Director 579-38-7200 77 932 Aug. Carolina Usual Residence of Decedent 28a-f shov of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No <u>Maryl</u>and Prince George's Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20706 6906 Presley Road United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🖾 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify: If Yes, Give 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8th Pastor Self-Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည David Hill Viola Mitchell Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annie M. Hill/ Spouse 6906 Presley Road Lanham, Maryland 20706 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o Fort Lincoln April 24, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify 2010 Brentwood, Maryland Cemetery 21. Signature of Funeral Service 22. Name and Address of Facility Stewart Funeral Home, Inc. 20019 DC 4001 Benning Rd. NE Washington, 23a. Part . Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Priysician/ disease or condition resulting in death) euman Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Exami Cause (Disease or iinjury requires that the death certificate be executed as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 attending properties of IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Fctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Other (specify) Month Day Year signed by the a Id be detached f Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed neec 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Hospital or Attending Physician: The law certificate has page 2 performed Yes 2 1 Yes 2 No 25. Was case referred to m→ cal examiner? 1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 FR/Outpatient 3 DOA မ After this funeral 27. Manner 28a. Date of injury (Month, Day, Year) eath 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury Matural 5 Pending ithin 24 hours after death.

the Funeral Director: A
ompleted filled in by the fu death. Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 6-2010 SM ddress of person who completed cause of death (Item 23a) (Type, Print) Name and 600 Canul 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 2 0 2010 Registrar

Phys /Me Exa

Fune Direc

_	State Registrar			State o					te of L					Reg. N	- 21	0 1	0	Itl	; 5
1	1. Decedent's Name	e (First, Midd	dle, Last)										ite of Dea		ay	Year	3.	Time of D	eath
		Par	trici	a Smi	th Ha	rtens	stin	e				Apr		21,	20	010	14	35	٨
4	la. Facility Name (f. Heron P					unity	,	4b. City		Location of Stert				40	c. Count	y of Dea	^{ith} Kent		
	5. Social Security N 418-32-	4906	6. Sex	м 2 Х Д F	7. Age <i>(In</i> 91	yrs. last bi	irthday) Yrs.	If Unde Months	Days	If Under Hours	24 Hrs. Min.	8. Da (M Apr	ite of Birt conth, Da	ıy, Year	919	C	rthplace lountry) laba	(State or I	Fore
1	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location													nside City					
	Maryland		Cecil						yvil	le								Yes 2	
1	621 Aike		10f. Zip Code 21903						10g. Citizen of What C										
1	11. Marital Status		12	2. Was Dece Armed Fo	orces?	in U.S.	13.	Was Dece If Yes, spe	edent of Hi	ispanic Ori ın, Mexicar	igin? (Sp n, Puerto	ecify Ye Rican,	es or No etc.)	•		ce - Am	erican In te, etc.	dian,	
·	1 ☐ Never Married 2 ☐ Married If ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No If Yes 2 ☑ No Specify: Specify: Specify:									fy:	White	е							
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	19a. Informant's Na			e. Print)				5		and Numb									_
	Anne H. F		ker		1.					Road								3461	3
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[21. Signature of Fu	uneral Service	e Licensee	Alle	N A 60		_ 22	2. Name a Lee A	and Addres Pat	ss of Facili	on &	So	n Fu	ner	al H	lome	P.,	Α.	
٠	- MAN MILL	1 4 4 4	1 1.617			$\sim \sim \sim$	/		Darr	rwil	10	Mar	vlan	<i>a</i> ')	1903	-n //	nh.		
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State Registrar

0-0327			Please Type or Print in Black Indelible Ink. Ensure All Cop		jible.	
Edward I			1- For State Certificate of Death	Re	2011 g. No.	
F Medical	Physici I Exam		1. Decedent's Name (First, Middle,Last) Edward Manget Harper	2. Date of Death Month April 28, 20		3. Time of Death 1032 hrs
			4a. Facility Name (if not institution, give street and number) 7101 Bay Front Drive # 207 4b. City, Town, or Location of De Annapolis		4c. County of Death	
	uneral		230 34 7714 1X M 2 F 04 Yrs.	Hrs. 8. Date of Birth Min. 2/20/	1926 Foreig	
70	daryiand 28a-f show any 1 at once.	'n	Usual Residence of Decedent 10a. State Maryland Anne Arundel 10c. City, Town or Location Annapol	is		10d. Inside City Limits
h the Maryl	n the Marys 3a or 28a-f totified at o	I Director	10e. Street and Number 7101 Bayfront Drive 10f. Zip Code 2140		g. Citizen of What Cou	usa
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Marvland	and a should be there within 72 nous aner death with the manyand feath and Mental Hygiene. tem 27 is marked Hygiene "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If yes, sieve year or Pates: 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No WWII 1 Yes 2 No specify:	erto Rican, etc.)	White, etc. Specify: Wh:	
2 hours	"natur Exam		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16b. Kind of Business/	ndustry
036 dithin 7	ed within A tygiene. other than the Medical	Completed	5+ Diplomat		US State I)epartment
21215-0036	tal Hygi ked oth nt, the	Be Co		ame (First, Middle, M a McGhee	aiden Surname)	
MD 213	thand Mental I 27 is marked umatic event,	101	19a. Informant's Name/Relationship (Type, Print) Alec Harper - Son 19b. Mailing Address (Street and Number 956 Nelson Place, A			, Zip Code)
more, I	perior. rages i and 2 si Department of Health ar Important: If item 27 injury or other traums		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Crematory	Date 5/4/2010	20c. Location - City or Baltimore	
Balti emit	Departm Imports injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility			
Phy	ysician	111	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia failure. List only one cause on each line.	cester St c or respiratory arres	,Annapo⊥13 st, shock, or heart	Approximate Interva Between Onset and
	ledical aminer		Immediate Cause (Final disease or condition resulting in death) a. Probable medication intoxication a Due to (or as a consequence of):	nd cuttin	g wounds	Death
		_	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
b	nsit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
e executed		g	AMENDED 23a,PII,27,28a-f,per ME g904 6/7/1	 በ		
3760, ficate b	g physicia s the buria	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of delivery	lay Year
Box 68	the attending ed for use as t	Physician/Med	past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown 1 Other (Specify) 9 Unknown		WOM!	ay (Gai
P.O.	signed by	اھ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes, Hypertension, heart disease, status		acco use contribute to	
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be	e has been si ge 2 should b	Completed	Post closed head injury	24a. Was ar autops perform	y prior to o ned? death?	topsy findings available
al Re	certificate	Be Co	25. Was case referred to medical examiner?		No 1 ✓ Ye	s 2 No
of Vit	After this of	၉	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other4 Nur 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?		esidence 6 🗸 Other	
/ision C	ter death. irector: Af n by the fun	Certification:	Natural Accident Natural Accident Natural Could not be No No	self_	w injury occurred LOOK drugs	al Route Number, City
	hours at uneral D ly filled		4 Homicide determined (Specify) residence			Front Dr
	within 24 h To the Fur	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.			
		Σ	29b. Signature and the of certifier O.C.M.E. 29c. License number O.C.M.E.		29d. Date signed (Mor April 29, 2010	ith, Day,Year)
\$1	h H		30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, M	D 21201		
	St	ate	31. Date filed (Morth RAY, YO' 3 2010 32. Registrar's Signature			

DHMH 17 Rev 1/2001 OCME 2006

Registrar

OCME

10-02998 Gerry Hance Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 4452 1- For State Certificate of Death Reg. No Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Month **Medical Examiner** 0813 hrs Gerry Wayne Hance April 17, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince Frederick Calvert Memorial Hospital Calvert 8. Date of 8irth(MM/DD/YYYY 9. 8irthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Funeral Director Months Days Hours Min Waryland 10/08/1956 220-66-9378 53 1 X M 2 F Yrs. Usual Residence of Decedent ıny 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a State Maryland Calvert St. Leonard 1 Yes 2 XNo 28a-f show timore, MD 21215-0036

1. Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 'natural", or items 23a or 28a-f sho Examiner must be notified at once. irector 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20685 United States 6441 Long Beach Drive 這 Funeral 12. Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Specify Yes or No. 14 Race - American Indian, Stack If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married Yes white 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: ۾ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of 8usiness/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Complet the Medical Master electrician construction 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ellen Bowen George Washington Hance is marked 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6020 Linden Rd. St. Leonard, MD 20685 Matthew W. Hance If item 27 20b. Place of Disposition (Name of cemetery, 04/24/20)10 20a, Method of Disposition 20c. Location - City or Town, State 8urial 2 Cremation 3 Removal from State Metropolitan funeral Service Alexandria Virginia tant: Donation 5 Other Specify: 22. Name and Address of Facility 21. Gignature of Euneral Service Licensee Rausch Funeral Home PA 4405 Broomes Is. Rd. Port Republic MD 20676 **Physician** 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed e attending physician and for use as the burial - tran hysician/Medical 28d, per ME G904 6/30/10 TT UNPENDED Box 68760, IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 立 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ě 1 Yes 2 ✓ No 3 Probably 4 Unknown Atherosclerotic Cardiovascular Disease Completed Records, page 2 should peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has performed' death? this certificate ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) of Vital Be examiner? Other Nursing Home 5 Residence 6 Other: 1 Yes 2 No 28a. Date of Injury (Month, Day Year) Apr 17, 2010 After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work' 28d. Describe how injury occurred subject driver jected operator of motorcyce of a Natural **UNKNOWN** Division 1 Yes 2 V No Director: Pending 2 🗸 Accident <u>motorcycle struck a tree</u> Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) Long Beach Dr. & Magnolia Circle, Saint Leonard, MD determined (Specify) Local Street Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) O.C.M.E. April 18, 2010 100 i 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day Year) A PR 2 2 2010 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Donald E. Joseph, 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** If Under 2 8. Date of Birth 9. Birthplace (State or Foreign DE Country) **Funeral** 1 🔀 M 2 🗆 F Months Days Hours Min. (Month, Day, Year) 7-22-1952 Director 57 222-38-4120 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No DE Sussex Seaford 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 19973 USA 701 S. Market Street 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: White Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Confidential Elementary/Seconday (0-12) College (1-4 or 5+) Security Guard Security Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) June Terroy <u>Melvin Joseph</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 500 So. Market St., Seaford, DE 19973 Donald E. Joseph, Jr./Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Tremation 3 Removal from State Direct Crematory, 4-26-2010 Dover, DE 4 Donation 5 Other (Specify) 22. Name and Address of Facility 917 W. Isabella St. Bennie Smith Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death ₽nysician/ disease or condition Medical resulting in death) . Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Pregnant at time of death 1 Yes 2 9 Unknown 2 No been signed by the sahould be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate has all director, page 2 s 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 🗌 Yes 2 1 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, within 24 hours after ueau...
To the Funeral Director: After th' 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Ectifying Physician. To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated OM 3a) (Type, Print) 100 E. CAKROIL 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

10f. Zip Code

20712

а М

10g, Citizen of What Country?

14 Race - American Indian

UNITED STATES

death with the Maryland 28a-f shov iner must be notified at ō 23a Pages 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 ō natural" than " ris marked other of Health item 2 Department of Important: If it any Injury or conce.

Physician

/Medical

10a State

10e. Street and Number

2701 WEBSTER STREET

APT#4

MD

Direct

Funeral

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Completed

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Examine

Physician/Medical

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Completed

Be

Certification: To

Medical

31. Date filed (Month, Day, Year)

APR 2 8 2010

Examiner

Funeral

Director

Physician /Medical Examiner

physician and s the burial-trans attending p been signed by the should be detached cate has director this funeral After 24 hours after death Funeral Director: filled in by

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O.

Box 68760.

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 ☐ Never Married 2 ☐ Married Specify: BLACK 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **SECRETARY** 12 USDA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MALICAH LINDSAY CATHERINE DOCKERY HYSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) daughter 2701 WEBSTER ST. APT#4 MT. RAINIER, MD 20712 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 20a Method of Disposition 1 🚂 Burial 2 🗆 Cremation 3 🗀 Rg 4 / 42 / 2010 MT. OLIVET CEMETERY WASHINGTON, DC 5 ☐ Other (Specify Donation 22. Name and Address of Facility JOHN T. RHINES FUNERAL HOME, LLC of Funeral Ser Signatu ensee 3005 12th ST. NE WASHINGTON, DC 20017 a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 1mmediate Cause (Final CARDIOPULMONARY ARREST disease or condition resulting in death) Due to (or as a consequence of): MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) SEPTICEMIA Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 □Yes 2 🕻 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tyes 2★ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Tyes 2 D No 2 **X** No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 kNursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier APRIL 22, 2010 D46529

State Registrar

DHMH 17 Rev 1/2001

within 2.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VICTOR ONYEJIAKA 7325A HANOVER PARKWAY GREENBELT MD 20770

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>010</u> Physician/ Ella Mae Stocks Jones 11:52 A.M 14 April Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Fort Washington Fort Washington Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Date of Birth (Month, Day, Year) anuary 27, 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 🗶 F Months Hours North Carolina 89 Director 578-24-8536 January Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits notified at 10c. City. Town or Location filed within 72 hours after death with the Maryland Director 1 X Yes 2 □ No 28a-f Maryland Charles Bryans Road 10e Street and Number 10f Zip Code ms 23a or 10g. Citizen of What Country? Funeral 20616 United States 7713 Garden Court items 14. Race - American Indian, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Was Decedon. Armed Forces? 1 ☐ Yes 2 🛣 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ö ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", 3 X Widowed 4 □ Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Page 1 and 2 should be filed within 73 ment of Health and Mental Hyglene. sant: If item 27 is marked other than ury or other traumatic event, the Me life, DO NOT use retired) nentary/Seconday (0-12) College (1-4 or 5+) Supervisory Housekeeper National Lutheran Home 11th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Cornelia Stocks (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5613 Greenview Drive; Oklahoma City, Oklahoma 73135 George Jones (Son) $\textbf{Apri} \overset{\text{Date}}{1} \textbf{23,20} \overset{\text{20c. Location - City or Town, State}}{1}$ 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Quantico, Virginia Quantico National Cemetery Sonature of Ameral Service Lie 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 2001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Seizure Disorder disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Pancreatic Mass Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) should be detached g | Linknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Hypertension Completed been Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed?

1 Yes 2 No has page 2 certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 ☐ Yes 2 X No 1 Inpatient 2 X ER/Outpatient 3 IDOA မ 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred s after death. Certificate: (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation the 1 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined building, etc. (Specify) City or Town, State 24 hours Funeral Medical 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 7 only one 29b. Signature a 29d. Date signed (Month) April s of person who completed cause of death (Item 23a) (Type, Print) M.D.; Kanika Hampton, 3510 Old Washington Road; Waldorf, Maryland 20602 32. Registrar's Signature Date filed (Month, Day, Year) State APR 2 8 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ April 1 M Johnson Inez 2010 0450Α 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Park <u>Takoma</u> <u>Hospita</u> Adventist Washington If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Hours (Month, Day, Year) 1 M 2 St F Director 577-32-5456 84 0/15/1925 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland Director must be notified 28a-f 1 Xes 2 No D.C. Washington D.C 10e. Street and Number ъ 10g, Citizen of What Country? Completed by Funeral Page 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. In the 27 is marked other than "natural", or items 23a ury or other traumatic event, the Medical Examiner must b 1400 Florida Ave N.E.#605 20002 S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Provider Private Child Care 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Lottie Edwards Charlie Edwards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1409 Elkwood Lane#202 Cap. Hgts. MD.20743 Hugh Johnson Jr. - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important; If ite any injury or oth 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 4/26/10 |Suitland.Md.20746 incoln Memorial 22. Name and Address of Facility Hodges and Edwards gnature of Funeral Service Licensee Hill Rd.Suitland Md.20746 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final dise we or condition Onset and Death Filysician/ Medical resulting in death) Examiner Sequentially list conditions, light years leading to the cause. Enter Underlying Cause (Disease or iinjury Examine attending physician and for use as the burial-transit -hevo Hospital or Attending Physician: The law requires that the death certificate be executed Cardiovasculo that initiated events resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death been signed by the should be detached 1 ☐ Yes ∠.e. 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 Ne 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed after death.

Director; After this certificate I
d in by the funeral director, page 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: ပ 2 D NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 1
Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death place, and due to the cause(s) and manner stated.
3 Centrying Nurse Fractioners 1. The basis of my included a control at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year) State Registrar

831

BLUD Sast, Silver Spup Univerself 32. Registra 's Signature

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAHA IN A

00060 luo

04-20-10

AHM GO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 2010 Robert Leroy Jadwin 12:16a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2591 Liberty Grove Rd. Colora Cecil 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country)
 NTV 1 🙀 M 2 🗆 F Months Days Hours ^vT930 Director 118-22-6884 79 NY Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Ceci1 Colora 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 21917 USA 2591 Liberty Grove Rd. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates White 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Specify: Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "I Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Mechanic Cable permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Irene Burch Charlie Jadwin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucille M. Jadwin / 2591 Liberty Grove Rd. Colora, MD 21917 Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Brookview Cemetery 4/29/2010 Rising Sun, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 111 S. Queen St. Rising Sun, MD 21911 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 1ears Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or ilinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: nse . 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day Year 2 No detached 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page performe Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending injury after death. 1 Tes 2 No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of

Registrar
DHMH 17 Rev 7/2009

State

126 A, E High St, Election MD 21921

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
S. S. FACHDEV ND 126 A, E +

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Day Year Magalene Catherine Jones-Thomas April 22, 2010 8:45 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death **Burnett-Calvert Hospice House** Prince Frederick Calvert 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 N F Months Days Hours Director 212-24-4279 February 3, 1922 MD Usual Residence of Decedent death with the Maryland 10a State 10b County 10c. City, Town or Location er than "natural", or items 23a or 28a-f show 10d. Inside City Limits Director 1 ☐ Yes 2 XNo MD Calvert Prince Frederick 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 280 Shore Acres Way Apt. #145 20678 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐Yes 2 🗷 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐Yes 2 No Specify Specify 3 Nidowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) 2 should be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Beautician Self-employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evone. ပ Louis C. Jones Iva Randall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anis Abdus-Salaam - son 1408 Ritchie Marlboro Road C6, Capitol Heights, MD 20743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Hope UM Church Cemetery | April 26, 2010 | Sunderland, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Sewell Funeral Home, P.A. Bladys q. 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence Examiner rebrova Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine se Vere and Due to (or as a consequence of): P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year signed by the a d be detached for 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 □ Yes 2 🖳 No 2 🗆 No Division of Vital 1 ☐ Yes Hospital or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 ☐ Nursing Home 5 ☐ Residence 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 6 Sother (Specify) 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending after death | Director: / d in by the f 2 Accident investigation 1 ☐ Yes 2 ☐ No ☐Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) To the within 2 29b. Signature and title of certifier

dew 3

State

DHMH 17 Rev 1/2001

Registrar

7 a 2 dani, M 32. Registrate Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KIOUMARCE
31. Date filed (Month, Day, Year)

- pares

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 14459 Lawrence Francis Kipple State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle Last) 2. Date of Death 3. Time of Death **Medical Examiner** 1517 hrs Lawrence Francis Kipple May 1, 2010 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death c. County of Death Glen 6 Lot 129 Earleville Cecil **Funeral** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Director Months Days Hours 180-42-6375 1 X M 2 F 58 Yrs Nov. 22. Country) PA Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show Examiner must be notified at once. 1 Yes 2 X No Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Ceci1 Earleville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Glen 6 Lot 129 21919 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? 1 Never Married 2 Married White etc. 2 X No Yes 3 Widowed If Yes, Give Year 4 XDivorced Yes 2 X No specify: Specify: White 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) If item 27 is marked other than "her traumatic event, the Medical 12 Salesperson Sales 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Walter F. Kipple Rosemary A. Fitzpatrick ို 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosemary Kipple/ Mother 8520 Jeans St. Philadelphia, PA 19111 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 5/4/2010 Donation 5 Other Specify Foard Funeral Home, P.A. Rising Sun, MD 21. Signature of Funeral Service License 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 318 George St. Chesapeake City, MD 21915 Part I. Enter the disease, or complica fons that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval Between Onset and /Medical Atherosclerotic cardiovascular disease Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of): (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): that the death certificate be executed Physician/Medical UNPENDED AMENDED 23a, PII, 27, per ME g904 6/21/10 TT the attending physician ed for use as the burial -Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö 23e. Did tobacco use contribute to the cause of death? ģ σ. Diabetes mellitus 1 Yes 2 No 3 Probably 4 Unknown The law requires Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy icate has l page 2 sh prior to completion of cause of performed death? ✓ Yes 2 No 1 🗸 Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) of Vital Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 Other 4 Nursing Home 5 Residence 6 🗸 Other: Scene DOA this 1 Yes 2 No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural n 24 hours af er death.

ne Funeral Director: A
pletely filled in by the fu 1 Yes 2 No Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Suicide 6 Could not be or Town, State) determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 2, 2010 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year, State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3, Time of Death Physician/ April 17, 2010^{eai} 12:13A Mary Louise Krupka . Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kent Rock Hall 5794 Liberty Street 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Funeral 1 🗆 M 2 🗶 F Months Days Hours 10/1/1915 94 DE Director 167-54-5870 Usual Residence of Deceden th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a. State Director 1 X Yes 2 ☐ No Rock Hall MD Kent 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral USA 5794 Liberty Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be file rtment of Health and Mental I-rtant: If item 27 is marked of ပ္ Charles Shelton Mary Mabrey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1165 Lockwood Chapel Rd. Hartley, DE 19953 Ed Krupka/brother-in-law permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 A Burial 2 Cremation 3 Removal from State 4/20/2010 Millington, Maryland 4 Donation 5 Other (Specify) Millington Asbury 21. Signatu Funeral Service Ligensee 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home Jary 30 Speer Rd. Chestertown, MD 23a. Part 1. Enjecthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death -ailure Immediate Cause (Final Hear Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 20gr. 0,005 Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Examine THE BY DO BE BE BY COMPANIES OF A and -transit that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) burial attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Month Day Pregnant at time of death been signed by the sahould be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, To the Hospital or Attending Physician: The law requires Completed Were autopsy findings available prior to completion of cause of 24a. Was an cate has t autons death? Yes 2 No 1 Yes 2 No certificate Division of Vital | 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Hospital Other: 1 🗆 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director. After thi completed filled in by the funeral of 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1-Natural 5 Pending M Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3. Excertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title pt 0 cause of death (Item 23a) (Type, Punt) sale

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31. Date filed (Month.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Aonth 4 Day Year 40(M 2010 15 /Medical 4b. City, Facility Name (If not institution, or Location of Death 4c. County of Death Examiner 13 0115 200 Year If Under 24 Hrs. Date of Birth (Month, Day Social Security Number 6. Sex (State or Foreign **Funeral** Months Days Hours Min 1 XM 2 ☐ F 227-88-416 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location iral", or Items 23a or 28a-f show Examiner must be notified at 1 XYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2161 Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Yes Give Baltimore, Maryland 21215-0036 "natural", or Yes, Give ear or Dates: 1 ☐ Yes 2 No Completed by Black 3 Widowed 4 Divorced er than "natura", the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event, the M aborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) priseea 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐Removal from State Wesle 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Bennie orton, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 10501 disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence offy Examiner To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician a for use as the burial-1 Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal dea:
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 □ Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been signated; page 2 should t 1 ☐ Yes 2 💓 Ño 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 2 **N**No 25. Was case referred to medical examiner?
1 X Yes 2 No Be 26. Place of Death (Check only one) Other: Yo the trooper within 24 hours after death.

To the Funeral Director. After this σ Certification: To 1 🔲 Inpatient 2 XER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural (Month, Day Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier cause of death (Item 23a) (Type, Print) 30. Name and address of person who comply

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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Montal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show a injury or other tranuatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Nu 1904	_{mber} Bauman 1	Dri	ve				10f. Zip	Code 0743				-	tizen of Wha Inited S		•
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ours af	핡	15. Decedent's E	ducation (Spe	cify o	or Dates: only highest gra	de completed)	16a	a. Decedent	's Usual	Occupat king life.	ion (Give I DO NOT	kind of w	ork done ed)	16b.	Kind of Bus	iness/l	ndustry
36 nin 72 h e. than "n chical E	Completed	Elementary/Seco			College (1-4 or 5+)		Studen					•	Ш	Student		
21215-0036 and be filed within 7 Montal Hygiene. marked other than		17. Father's Name	(First, Middle										(First, Middle,		n Surname)		
2121 Ald be fi Mental narked event,	o Be	19a. Informant's Na	nd D. Kn				1	9b. Mailing	Address	(Stree			e Philli ural Route Nu		City or Town	, State	, Zip Code)
MD 2 shou alth and 1 is r aumatic	1	Toni & E					Ï					apita	1 Height				
ore, es 1 and of Heal of Heal If item	I	20a, Method of Dis 1 XXBurial 2		n 3	Removal f	rom State	crem	of Disposi atory or oth	er place)		. /00	Date	ı	Location -	•	
Baltimore, permit. Pages I ar Department of Hee Important: If ite	ŀ	4 Donation 5 21 Si to ture of F	Other S	pecif	nsee	R	esui	rection 22. N	n Cen ame and	etery Address	of Facility		/2010 uneral l		inton,		yiand Id Alexandria
Bal permi Depa Impo injur	J	Tours	T. The	1	L mo	0251		F	erry	Road	, Clin	ton,	Maryland	1 20	0735		
Physician Medical	4	23a. Part I. Enter the failure. List or	nly one cause	e on e	plications that of each line. Drowning	caused the deat	th. Do	not enter th	e mode	of dying,	such as c	ardiac or	respiratory a	rrest, sh	hock, or hea	rt	Approximate Interval Between Onset and Death
Examiner		Immediate Cause or condition resulti			Due to (or as	a consequence	of):										
	aminer	Sequentially list co if any, leading to in cause. Enter Under	mmediate erlying Cause		Due to (or as	a consequence	of):										
4.4	Exal	(Disease or injury events resulting in			Due to (or as	a consequence	of):										
e execution and cian and inial - tra	sician/Medical	UNPENDED)	\exists	AMENDED						_						-
8760 ificate b	₩ W	IF FEMALE: 23b. Was decedent		the	23c. If yes,	outcome of pre	egnand		tal death	3	Ectopio	c pregna	ncy	2	3d. Date of o		/ Day Year
Box 68760, e death certificate be the attending physic ed for use as the burner.	sicia	past 12 month 1 Yes 2		nknow	17	nant at time of	death	=	ner (Spe	cify)				ļ			
C the part of	by Phy	Part II. Other sign	ificant condi	itions			t result	ting in the u	nderlying	cause (given in Pa	art I.				_	the cause of death?
ds, Pequires t				•									24a. Wa	s an	24b. W	/ere au	utopsy findings available
Division of Vital Records, tal or Attending Physician: The law requir is after cleath. al Director: After this certificate has been siled in by the funeral director, page 2 should led in by the funeral director, page 2 should be a sh	ompleted										_			opsy formed? 2	? d	eath?	
tal Rician: T	Be	25. Was case refe examiner?			Hospital:	Innationt 2	ED	(Outpatient			of Death Other		only one) g Home 5	Resid	dence 6	Othe	r Scene
ding Physic. After this funeral di	27 Manner of Death 28a Date of Injury 28b. Time of Injury 28c. Inj							ry at Work	(?	28d. Describe	e how in	njury occurre	ed	swimming			
	Apr 20, 2010 1732 hrs Investigation Apr 20, 2010 2732 hrs							No					ıral Route Number, City				
Divisior Hospital or Attend 24 hours after death funeral Director: stely filled in by the	Certifi	3 Suicide 4 Homicide	det	ermin	ed (Specify	River 10-	-15 ft						or Town, Patuxent Riv	ver, Lo			
Divisior To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical (29a. Certifier (Check only one)	Certifying I	Physi amin	er:On the basis	est of my knowle s of examination	edge, on and/o	death occur or investigat	red at th ion, in m	e time, d y opinior	ate and plan, death oc	ace, and ccurred a	due to the ca t the time, dat	use(s) a e and p	and manner place, and de	as stat ue to th	ed. ne cau s e(s)
To 1 with To 1	Med	29b Signature and	_		and manner						se number			290	d. Date signe	ed (Mo	onth, Day, Year)
		()(a)	bent	w	bem					O.C.	M.E.			Ap	oril 21, 20	10	
		30. Name and add	iress of perso	n who	completed car	use of death (Ite	em 23a	3)									

BB2 State

Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Dev Year) 7 2010 32. Registrar's Signature

Registrar

(Check only one)

29a. Certifier

Physician

/Medical

Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Physician /Medical Examiner

Examiner

Medical Certification: To Be Completed by Physician/Medical

To Be Completed by Funeral Director

	Pleas				delible Ink. Ens		_	_	
For State Registrar		State of	Maryland /	-	rtment of Health		lental Hygle Reg.	001	11.1.63
1. Decedent's Name	(First, Middle,	Last)	-				2. Date of Death Month	Day Year	3. Time of Death
		ershner					APRIL à	3 2010	2 10:4/AM
		give street and numl			4b. City, Town, or Location			4c. County of De	
5. Social Security N		nd Hospita 6.Sex 7	. Age (In yrs. last			n er 24 Hrs.	8. Date of Birth	Washin 9. B	irthplace (State or Foreign
217-28-5379 1 M F 75 Yrs. Months Days Hours Min. (Month, Day, Year) 6/9/1934 Usual Residence of Decedent									aryland
10a. State 10b. County 10c. City, Town or Location									10d. Inside City Limits 1 Yes 2 □ No
MD	- Madela Count								
10e. Street and Nun		•			10f. Zip Code		10g.	Citizen of What (Country?
1500 Penr	isyivan		ent Ever in U.S.	13 V	21742	Origin? (Sne	ecify Ves or No.	U.S.A.	nerican Indian
1 □ Never Marri	ed 2 Marrie	Armed Ford 1 ☐ Yes 2	es? No	II. II	Vas Decedent of Hispanic C f Yes, specify Cuban, Mexic	can, Puerto	Rican, etc.)	Black, Wh	
3 Widowed		If Yes, Give Year or Dat	*	1	Yes 2 No Specia	fy:		Specify:	White
(Spec	15. Decedent's	s Education grade completed)	10	(Give i	lent's Usual Occupation kind of work done during m	ost of work		. Kind of Busines	s/Industry
Elementary/Secon		College (1-4	for 5+)	life. E	OO NOT use retired)				
11 17. Father's Name (First, Middle, L	.ast)		HO	memaker	ther's Name	De (First, Middle, Mai	omestic den Surname)	
John Fra		*			Ame	elia	Turner	, , , , , , , , , , , , , , , , , , , ,	
19a. Informant's Na	me/Relationshi	ip (Type. Print)	1	9b. Mailin	g Address (Street and Num	nber or Rura	al Route Number, C	ity or Town, State	, Zip Code)
George R	R. Kersl	nner / Hus	band 1	16 S	. Mont Valla	Ave.	, Hagerst	own, MD	21740
20a. Method of Disp		3 □Removal from Si	como	e of Dispos etery, cren	sition (Name of natory or other place)		Date 200	c. Location - City of	or Town, State
4 ☐ Donation	5 ☐ Other (Sp	ecify)			ing Ch. Cem.		/2010	Hagersto	wn, MD
21. Signature of Fu	neral Service	Censee			. Name and Address of Fac	KE	est Haven		
220 Bortl Folds	1	amplications that on	road the death. D		O1 Pennsy1var				MD 217/2 Approximate
shock, or hear	rt failure. List o	only one cause on ea	ch line.		. 0		or respiratory arrest,		Interval Between Onset and Death
disease or condition resulting in death)			10VENOUS r as a consequenc		HEPORMATIONS				YEARS
	1	Due to (o	as a consequent	se or).					
Sequentially list cor any, leading to im- cause. Enter Under	nditions,	b. Due to (o	гае и оспециале	be of y:					
that initiated events	injury	c							
resulting in death) L	ast	Due to (o	r as a consequenc	ce of):					
	'	d							
IF FEMALE:		23c If yes outer	ome pf pregnancy					001.00	
in the past 12	months?	1 ☐ Live bir	th 2 Fetal dea	ath 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of d Month	Day Year
1 □ Yes 2 2 9 □ Unknown	S-No	9□Unknov							
Part II. Other signif	icant condition	ns contributing to dea	th but not resulting	g in the un	derlying cause given in Par	t I.	23e. Did tobac	co use contribute	to the cause of death?
GASTROI	N TEST I	NAL BLE	ED				1 ☐ Yes	2 □ No 3 □	Probably 4 □Unknown
ANEMI	A						24a. Was an autopsy performed	prior to death	
25. Was case refer	red to medical				26. Pla	ice of Death	1 Yes 2 h (Check only one)	No 1 □Ye	es 2□No
examiner? 1 ☐ Yes 2 ∑	No	Hospital: 1 ☐ In	oatient 2 ER/	Outpatient	0.15		me 5 ☐ Residenc	e 6 □Other (S	pecify)
27. Manner of Death 1 Anatural 2 Accident	n 5	· ·	Injury 288 Day Year)	b. Time of Injury			28d. Describe how		
3 Suicide 4 Homicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)						Rural Route Number,			

To the Hospital or Attending Physician: The law requires that the death certificate be executed page 2 should be detached for use as the burial-transi After this certificate

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

34-3

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PAULINE DALEY RICHARDS

29c. License number

29d. Date signed (Month, Day, Year)

D0062895

2010

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1500 Pennsylvania Avenue Hagerstown, MD

DALFY RICHARDS APR 23 2010



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 5 per fh \$903 5-13-10 and Mental Hygiene
State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . ^{Day} 20<u>10</u> April Physician/ 10:52 A M 17 Dorothy Jean Kane Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c, County of Death Examiner Anne Arundel Davidsonville 3501 Russell Thomas Lane . Age (In yrs. last birthday) 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8 Date of Birth 212-28-6643 6. Sex **Funeral** 1 □ M 2 XX Days Ohio June 83 Director Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director Anne Arundel Davidsonville Maryland 1 Yes 2XX No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 21035 3501 Russell Thomas Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12, Was Decedent Ever in U.S. Armed Forces Black White etc. by 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 🗆 Yes 2 💢 No Specify. Specify:White 3 XXVidowed 4 Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Alcohol & Drug_Abuse Counselor 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Eva Hueurilla Dan Fall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 3501 Russell ThomasLane, Davidsonville, Md. 21035 Jan M. Mazza/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Dulaney Valley Cem 4-23-2010 Timonium, Md. 4 Donation 5 Other (Specify) 21. Signatu / / / ral Seyfe Licensee 22. Name and Address of Facility 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, Md. 21037 Approximate Interval Between Onset and Death 23a. Fart 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ 5 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to inmediate cause. Enter Underlying Examiner Due to lor as a consequence of attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Control of the contro in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed?

1 Yes 2 No 1 Yes 2 No After this certificate ours after death.

eral Director. After this certification in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 은 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Certifying Nurse Practice on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Jeffery T. Hoeck 9c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 4-19-10 58089 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Jeffery T. Hoeck, MD, 4175 North Hanson Court, Bowie, Md. 20716 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month April **Physician** William Morris King, Sr. 2010 21 11:51 а м /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year, 7. Age (In yrs. last birthday) **Funeral** 1 3 M 2 □ F Months Days Hours 216-76-5435 Jan. 21, Director District of Columbia Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show Lry or other traumatic event, the Medical Examiner must be recitived at 10d. Inside City Limits Funeral Director 1 ☐ Yes 2 ☑ No Maryland Calvert Dunkirk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3504 King Drive 20754 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify \$ 3 Widowed 4 Divorced Completed Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Transmisition Specialist P. G. County Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph King, Jr. Katherine Willet King ၉ 19a. Informant's Name/Relationship *(Type. Print)* Ronnchey Lynn King / Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3504 King Drive, Dunkirk, MD 20754 20b. Place of Disposition (Name of cemetery, crematory or other place) Trinity Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 04/27/2010 Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 1 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. Lisa M. Mounts 8125 Southern Maryland Blvd., Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a conse uence of): Artery disease or condition resulting in death) /Medical **Examiner** tty Pertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Diabetes attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical verscular d'scarp eripheral IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) Division of Vital Records, P.O. been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy perform 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. ours after death. neral Director: A filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0068923 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 300

day 5

State Registrar VIJAYA

31. Date filed (Month, Day, Year)

GUDURI

DHMH 17 Rev 1/2001

130 Hospital Road

32. Registraris Signature

Prince Prederick

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 25, 2010 David Franklin Kefauver 5:15 April 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4559 Sixes Road Calvert Prince Frederick Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs Date of Birth (Month, Day, Year) Social Security Number 6 Sex 7. Age (In yrs. last birthday) Months Davs Hours 123 M 2□ F 220-16-3360 84 1925 Maryland May 1 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☑ No Maryland Calvert Lusby 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12130 Preston Drive 20657 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 № Yes 2 ☐ If Yes, Give Year or Dates: 2 □ No 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Public Health Administration U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Joseph Kefauver Margaret Eva DeLauter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Marlyn L. Kefauver / Wife 12130 Preston Drive, Lusby, MD 20657 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 04/26/2010 Alexandria, Virginia 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Rausch Funeral Home, P.A. P.O. Box 600, Lusby, Maryland 20657 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the touth. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) DISEASE OBSTRUCTIUS YEARS Due to (or as a consequence of) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue to for as a consequence of Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 □Yes 2 □No

Physician /Medical **Examiner** or Attending Physician: The law requires that the death certificate be executed

Physician

Examiner

Funeral

Director

show

Director

Funeral

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Completed

Be

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Marical Examination must be notified at once.

Baltimore, Maryland 21215-0036

death with the Maryland

/Medical

Examiner burial-tran ed by the attending physician detached for use as the buria Physician/Medical Be Completed by peen has

24 hours a er death. Funeral Director. After this certific etely filled in by the funeral director, i Medical Certification: To

Division of Vital Records, P.O. Box 68760,

9 LI Unknown											
	ontributing to death but not resulting in the underlying cause given in Part I. $ACOBACTERIUM$	23e. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown									
		24a. Was an autopsy performed? 1 Yes 2 SNo 1 Yes 2 No									
25. Was case referred to medical	26. Place of Death (Check only one)										
examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ② Other (Specify)										
27. Manner of Death ↑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day, Year) Injury Work? M 1 □ Yes 2 □ No	8d. Describe how injury occurred									
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (Street and Number or Rural Route Number, City or Town, State)									
	hysician: To the best of my knowledge, death occurred at the time, date and place, a niner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.										



Hospital

within 2 To the I

15+

29b. Signature and title of certifier

29c. License number D40370

29d. Date signed (Month, Day, Year) April 26, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peter L. Wisniewski, MD. 110 Hospital Rd., Suite 310, Prince Frederick, MD 20678

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar Signature

barker

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 1:50P M RAY HETZEL LAMBERT 4/18/2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 211 BONFIELD RD OXFORD TALBOT 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Hours 1**X** M 2□ F 11/11/1924 WEST VIRGINIA 85 **Director** 235-30-5632 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1¥ Yes 2 No Director MARYLAND **OXFORD** TALBOT 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 211 BONFIELD RD 21661 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ∐Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2X Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced WHITE Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) RESEARCH ANALYST RESEARCH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental H- Important: If them 27 is marked oth any injury or other traumatic event Be HETZEL W. LAMBERT EDNA EMMA STEELE ျှ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4669 BACHELORS PT. RD., OXFORD MD 21661 SUE SCHMITT / DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4/19/2010 CAMBRIDGE, MD 4 ☐ Donation 5 ☐ Other (Specify) MID SHORE CREMATION CENTER 21. Signature of Funeral Se 22. Name and Address of Facility MID SHORE CREMATION CENTER, 2272 HUDSON RD., CAMBRIDGE, MD 21613 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician (00 years disease or condition resulting in death) USCUla /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of) Exami burial-t Due to (or as a consequence of) Physician/Medical the as IF FEMALE: nse yes, outcome of pregnancy
Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy P Year Day Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes → No 3 ☐ Probably 4 ☐ Unknown winan Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 မ 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation (Month, Day, Year) 1 ☐ Yes 2 ☐ No 2 Taccident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

Baltimore, Maryland 21215-0036

is marked other

and

physician

the attending

signed by

certificate has

this (

After

P.O. Box 68760,

Division of Vital Records,

or Attending Physician;

the Hospital

The law requires that the death certificate be

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

)enten

MN

3. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

at Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner state().

29d, Date signed (Month, Day, Year)

MD 21601

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 22^{Day} Physician/ April Marjorie Hackett Lushin 2010 6:10 p.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Atria Assisted Living Salisbury Wicomico Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days June 25, 1918 Months 1 M 2 X F 218-16-6478 91 Maryland Director Usual Residence of Decedent 28a-f short 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Dorchester Cambridge 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? USA 10f. Zip Code 21613 Funeral 28 Algonquin Road Maryland 21215-0036 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc ģ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify. white Specify: Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 72 f Health and Mental Hygiene, item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) professor university 5+Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Luke J. Hackett Ola Wheatlev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Trader p.r. 28 Algonquin Road, Cambridge, MD or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 😨 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place)
East New Market Cem. 4/27/10 East New Market. MD 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee ik. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Failure to thrive Pnysician/ Medical resulting in death) Due to (or as a consequence of) Examiner Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): End Stage Alzheimer's Dementia Cause (Disease or linjury that initiated events resulting in death) Last burial-trai Due to (or as a consequence of): by the attending physician Physician/Medical certificate be Box 68760 the as IF FEMALE use yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 X No requires that the death fo Month Day Year Pregnant at time of death signed by the ar Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ♣ Unknown Completed peen 24b. Were autopsy findings available 24a. Was an autopsy performed?

Yes 2 1 Nc Finasprier -124 hours after death.

Funeral Director: After this certificate has the funeral director, page 2 standards. prior to completion of cause of death? 2 🗆 No 1 Yes 25. Was case referred to medical or Attending Physician: 26. Place of Death (Check only one) Be assisted examiner? Other: 4 \(\to \) Nursing Home 5 \(\to \) Residence 6 \(\to X\)Other (Specify) 2 K No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA living 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending work?
1 Yes 2 No within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu ☐ Accident ☐ Suicide M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29b. Signat 29d. Date signed (Month. 29c. License numbe R089536 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Crum, CRNP 1110 Healthway Drive, Salisbury, MD 21804 31. Date filed (Month, Day 32. Regis ar's Signature

State

Registrar

APR 37

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** Day Year Lillian Jean Lewis /Medical 4:20p 2010 April 11 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Hospital Cheverly
If Under 1 Year | ff Under 24 Hrs. Prince Georges

9. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) (In yrs. last birthday, **Funeral** Days Hours 1 □ M 2 🔀 F Months Min Director 218-58-1349 11/09/1949 Wash, DC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Directo 1 ☐ Yes 2√ No MD Prince Georges Upper Marlboro 10e. Street and Number 10g. Citizen of What Country? 12030 Van Brady Rd Funeral 20772 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 TNo Specify: 3 ☐ Widowed 4 ☑ Divorced 'natural" White Completed 7 is marked other than "natu-traumatic event, the Wedical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 9th Homemaker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be ind Mental Robert Ramsey Jean Thomas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any Injury or other trau once. <u>Judy Ramsey Daughter</u> 12030 Van Brady Rd UpperMarlboro, MD 20772 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State M☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Washington National 4/17/2010 Suitland, MD 22. Name and Address of Facility
W. Wesley Chavis III Funeral Service P.A.
10684 Southern MD BLVD Dunkirk, MD 20754
ADDROXIMATE 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** oronary /Medical Examiner Vend Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) 4 ☐ Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ icate has been signal page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 24 hours after death.

Funeral Director: After this certificate has autopsy performe Yes 2 1 ☐ Yes Hospital or Attending Physician: npletely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) **≫** No 1 ☐ Yes 1 Inpatient ٩ 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 27. Manner of Death
1 Natural
2 Accident 28a. 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only the 29b. Signature at 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Matir Hospital Dr Cheverly MD 20785 3001 31. Date filed (Month, Day, Year, State ack APR 1 6 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dollie Miller 2010 Apri 8 :05 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Thomas More Nursing & Rehab.Ctr Prince George's Hyattsville Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** · Carolina 1 🗆 M 2 🔀 F Days Months Hours Min. Director 215-20-2794 96 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location Director Yes 2 No D.C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5929 East Capitol St., S.E. 20019 U.S.A. 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: permit. Page 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar Black 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Domestic Private Industry 9±h Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rufus Dunlap Sallie Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Genevieve Matthews/Sister 4800 E. Capitol St., N.E. # 117, Wash., D.C. 20019 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Ft. Lincoln Cem. 04/22/10 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
H.S. Washington & Sons
4925 Burroughs Ave., N.E., s Co., Inc. ...Washington, D.C. 20019 acre 1 all 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician Arrhythmia disease or condition mths Medical resulting in death) Due to (or as a consequence of): Examiner Myocardial Infarction 5 mths Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to jor as a consequence of that the death certificate be executed Hypertension Years and -tran resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, The law requires Completed Cerebrovascular Accident 1 🔲 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Paget's Disease s certificate has b lirector, page 2 s performed? autopsy death? 1 Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Tyes 2 🔁 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending death. 1 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director: / 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3

State Registrar 29b. Signature and title of certifier,

Raman Tuli, M.D. 31. Date filed (Month, Day, Year)

APR 2 3 2010

30. Name and address

of person who completed cause of death (Item 23a) (Type, Print)

32. Regionar's Signature

29c. License number

10810 Darnestown Road Suite 202, Gaithersburg, Maryland 20878

29d. Date signed (Month, Day, Year) April 22,2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Honth 51 Edward J. McCloskey, Sr. 12:05PM 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Doctor's Community Hospital Lanham Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, November 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) 1 ፟ M 2 ☐ F Days Hours Min. 25,1921 Washington, DC 179-12-8618 88 Director Yrs. Usual Residence of Decedent 28a-f shov 10a, State 10b. County death with the Maryland 10c. City. Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Maryland Prince George's Brentwood 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral items 23a 3814 37th Place 20722 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give WWTT 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ò ģ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: "natural", Specify: White Completed 3 Widowed 4 Divorced WWII Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. filed within Elementary/Seconday (0-12) College (1-4 or 5+) Antique Reproductions Picture Framer Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be Edward McCloskey Marie Crumback 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward J. McCloskey, Jr. / Son 4025 34th Street, Mt. Rainier, MD 20712 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Fort Lincoln Cemetery 4/29/2010 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final shy somo Physician/ disease or condition resulting in death) Medical Due to or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending p IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Dav Year signed by the a 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page performed' 2 🗌 No Yes 2 ANO 1 Tes 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital Other: ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work?
1 ☐ Yes 2 ☐ No Accident Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral I completed filled Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 52815 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760

loes

700

32. Registra s Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 2010 2:38pM 20^{3} William Wesley Miller Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cecil F1kton Union Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Min. Hours Oct. 28 Pear) 1932 1 XM 2 □ F Months PA Director 164-26-0225 77 Usual Residence of Decedent show 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location Director 1 ☐ Yes 2X No Cecil E1kton 10e, Street and Numbe 10f. Zip Code 10g, Citizen of What Country? **Funeral** 21921 USA 626 Frenchtown Rd. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examinar mu 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Year or Dates. 1953-61 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Paper Manufacturing Machinist 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ဂ္ Anna Mae Baum Clifford William Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 155 New Derry, PA 15671 Judith D. Miller/ Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4/24/2010 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cherry Hill Methodist Cemetery Elkton, MD 21. Signature of Name and Address of Facility T. Foard and Gee Elkton, MD 21921 Main St. 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events HERESCLERATIC CORONARY burial-transit and resulting in death) Last attending physician for use as the burial Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year Pregnant at time of death signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð To the Hospital or Attending Physician: The law requires twithin 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Hospital Other: 2 🗆 No 1 ☐ Inpatient 2 ☐ ER/outpatient 3 ☐ DOA ျ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person who complete

DILLEN

22647

106 BOW ST

UHCC

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 20<u>10</u> Physician/ April Elva Jane Morris 9 15:22P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Union Hospital E1kton Cecil If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 M 2 X F Hours Min. 5/5/1926 Director 214-76-3885 83 MD Usual Residence of Decedent show Department of Health and Mental Hygiene.
Important: If fam 27 is marked other than "--any injury or other than "----10b County 10a. State 10c. City, Town or Location 10d. inside City Limits Director 1X Yes 2 □ No Cecil E1kton 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 1290 Pulaski Hwy. 21922 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married ş 1 ☐ Yes 2X No Specify White Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Disabled Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence Henry Morris Addie Maywood Biddle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Mae Roe/ sister 9905 Flatland Rd. Chestertown, MD 21620 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Church Hill Cemetery 4/14/10 Church Hill, MD 21. Signature of Funeral Service Licenses ²² Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home 130 Speer Rd. Chestertown, MD 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Previnonia Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or ilinusy that initiated events resulting in death) Last Examine Due to (or as a consequence of) and Due to (or as a consequence of) attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE nse yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown ğ Month Year sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ with Barrets Esophagits The law requires 1 Yes 2 No 3 Probably 4 Unknown Mental retardation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 25. Was case referre to medical within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 1 Yes 2 No or Attending Physician; Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Minpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one)

ms

DHMH 17 Rev 7/2009

State Registrar

29b. Signature and title of certifier

Robert al Montele

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Monteleone, MO

00053675

111 W. High St. Suite 214, Elkton MD 21921

29d. Date signed (Month, Day, Year)

0-03071 ndrew Roy Mc			oe or Print in ate of Maryla	and / Depai	rtme	nt of			•	_	jible.	201	0	1447			
Physici	an/	Registrar 1. Decedent's Name (First, Middl			ilica		Jeaui			Re Date of Death Month		Year	- 1	Time of Death			
ledical Exami	ner	Andrew Roy Mo				- 1546	. City, Town, or	-1	A	pril 19, 20		County of D		2147 hrs			
		4a. Facility Name (if not institutio 20125 Aquasco Road					Aquasco				Pr	ince Geo	rge's				
Funeral Director		5. Social Security Number 212 98 3774	6. Sex	7. Age (In yrs. las	st birth	day) Yrs.	Months Day			Date of Birth Sept 18		1	Countr	ace (State or Foreig y) erly, MD			
d how any		Usual Residence of Decedent 10a. State 10b. County Maryland St. Maryland	arv¹s	10c. City, 1		r Location	1						- 1	d. Inside City Limits			
the Maryland a or 28a-f show	Director	10e. Street and Number 25408 Three No					10f. Zip Code 20636			10	_	en of What	_				
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Marital 3 Widowed 4 Div		2 No		If Yes	Decedent of His , specify Cubar res 2 X No	n, Mexican	, Puerto Rica		1		merican c.	Indian, Black,			
16 n 72 hours a an "natural ical Examin	eleted by	eleted by	pleted b	Completed b	15. Decedent's Education (Spec Elementary/Secondary (0-12)	15. Decedent's Education (Specify only highest grade completed)			ecedent's uring mos	Usual Occupa t of working life	tion (Give	kind of work	done	16b. Kir	nd of Busine	ess/Indu	•
21215-0036 Juld be filed within 7 Mental Hygiene, marked other than	mo	1∠ 17. Father's Name (First, Middle,	Last)			lechar		18.Mother	's Name (Fir	st, Middle, M			vy E	quipment			
215 be file ntal Hy rked o	a	James E. McKenz	zie							h H. Ga							
D 21 should and Me	٩	19a. Informant's Name/Relations				_	Address (Stree							Code)			
mand 2 sho fealth and tem 27 is traumatic		Darlene McKenzie 20a. Method of Disposition	(Spouse)	20b. Pl			Three No			Hollywo ate		1D 2063 cation - Cit		m, State			
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		1 X Burial 2 Cremation 4 Donation 3 Other Sc 21 Signature of Funeral Service		on otate		22. Na	nurch Cem	s of Facility	Lee Fu		Uppome,	per Mar Inc 663	1boro 3 01a	o, MD I Alexandri			
	_	23a. Part I. Enter the disease, or	complications that ca	aused the death. I	On not		ry Road,			20735	st shock	k or heart	I A	oproximate Interval			
Physician /Medical Examiner		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line. a. Intraoral sh	otgun wound			mode of dying,	, 00011 00 00		prictory circo		., 0, 110011		Between Onset and Death			
		Sequentially list conditions,	Due to (or as a b.	consequence of):													
	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a	consequence of):	:												
executed an and al - transit	l Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):	:												
be exectician aurial - t	dica	UNPENDED	AMENDED														
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in th past 12 months?	1 Live b	ant at time of deal	2		death 3	Ectopic	pregnancy			Date of deli Ionth	very Day	Year			
P.O. Bost that the designed by the conference of	by Phy	Part II. Other significant conditi	9 Unkno		ulting	in the und	lerlying cause o	given in Pa	ırt I.			se contribute		cause of death?			
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the rs after death. al Director: After this certificate has been signed by the funeral director, page 2 should be detached in by the funeral director, page 2 should be detached.	ompleted									24a. Was ar autops perforn	n y ned?	24b. Were prior death	autops to comp	y findings available letion of cause of			
Vital Reco hysician: The law this certificate has I director, page 2 s	ပြု	25. Was case referred to medical					26.Place	of Death ((Check only	ا لستا	No	1 🗸	Yes	2 No			
1 of Vital Rec ling Physician: The l After this certificate l	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 l	npatient 2 E	R/Out	patient	3 DOA	Other 4	Nursing Ho	ome 5 R	Residenc	ce 6 🗸 O	ther: Sc	ene			
ion of trending Pl leath. tor: After the funeral	cation: 1	27. Manner of Death 1 Natural 5 Pend 2 Accident Inves	ling 28a. Date (Month, Apr 19, 2	of Injury Day Year) 2010	28b. Ti 0000 l	me of Inju hrs		ryat Work Yes 2 ✔	Sut	. Describe ho pject shot		occurred					
Divis	Certific	3 Suicide 6 Could	d not be 28e. Place	of Injury - At hon Driveway	ne, farr	n, street,	factory, office b	ouilding, et		Location (St or Town, Sta 25 Aquasco				Route Number, City			
Divisior To the Hospital or Attend within 24 hours after death. To the Funeral Director:	edical	one) 2 Medical Exam	nysician: To the bes miner:On the basis of and manner st	of examination and										use(s)			
F \$ F 8	M	29b. Signature and title of certifie		7)		29c. Licens O.C.I					te signed (20, 2010		Day, Year)			
RRO		30. Name and address of person Zabiullah Ali, M.D.	who completed caus Assistant Medic			l Penn	Street, Balt	imore, N	/ID 21201								

State 31. Date filed (Month, Day, Year)
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Gayl Elaine MARTIN Pri 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8 Date of Birth **Funeral** 1 M 2 X F Months Month, Day, Feb. 5 1934 **Director** Pennsylvania 76 214-30-1727 Usual Residence of Decedent show 10a. State 10h. County 10c. City. Town or Location within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11101 Lakeside Court Lot 190 21740 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. δ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Widowed 4 Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Foreman Leather Mfg. Be should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur E. Nye Gladys E. Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles L. Martin - Husband 11101 Lakeside Court, Lot 190, Hagerstown, MD 21740 Page 1 and 2 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Rose Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 4/28/10 Hagerstown, Md. 21740 Signature of Funeral Service License 22. Name and Address of Facility Minnich Funeral Home Ε. Wilson Blvd. Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examine or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months
1 Yes 2 No Month Day signed by the Part II. Other significant conditions contributing to death but not resulting in the upderlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ANO 3 Probably 4 Unknown 1 Yes Completed 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy performed? death? After this certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 INO Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital or within 24 hours af To the Funeral Di Medical 14 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar
DHMH 17 Rev 7/2009

30. Name and address of person

APR 28

2010

31. Date filed (Month,

death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20 Year Month 8:03 AM Rose McCabe Suzanne Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** comic If Under 1 Year If Under 24 H 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Months Davs Feb 20 1932 Johnstown, PA Director 165-24-9045 78 Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 ☐ Yes 2 🙀 No Selbyville DF Sussex 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ō permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be I Funeral 37095 Cygnet Drive 19975 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2 No If Yes, Give Completed by 1 Never Married 2 X Married DE JUZANN (*) Maryland 21215-0036 white 1 Tes 2 No Specify: Specify: 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Communications Telephone Operator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Raymond Hipp unavailable 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 37095 Cygnet Drive Selbyville, DE Hugh F. McCabe 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Unfreers far of of other place) 1 Durial 2 Cremation 3 X Removal from State 4 □ Donation 5 □ Other (Specify) Newark, Delaware Delaware Sonature of up to Licensee Wilmington, DE 19803 22. Name and Address of Facility Chandler Funeral Home 2506 Concord Pike 28a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Car cenon Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4 Pregnant : 9 Unknown Pregnant at time of death Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy Yes 2 No After this certificate I funeral director, page 1 ☐ Yes 2/☐NO 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence Other (Specify) P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes 2 No Natural 5 Pending within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur Investigation Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

CHurtan

31. Date filed (Month, Day, Year)

1600

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0)005 8410

Stab Bury up

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Ye ar 155 **Physician** 24 2010 -amont Apri Jeorge /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospita Birthplace (State or Foreign Date of Birth (Month, Day, Year) Security Number 6. Sex 1 M 2 □ F **Funeral** Country) Months 214-36-7218 71 Director 10/22/1938 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examination at the modified at 1 ☐ Yes 2 X No MD Oueen Anne's Chestertown Director 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number 104 Pine Chip Rd. 21620 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates: 56-59 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 Printing & Printing Elementary/Secondary (0-12) College (1-4or 5+) Salesman Products 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item Z7 is marked oth any linjury or other traumatic event size. Be Alice Warner William E. McClary, Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 104 Pine Chip Rd. Chestertown, MD 21620 Sandra H. McClary/wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)
21. Signature of Funeral Service Licensee Chester Cemetery 4/28/10 Chestertown, MD and Address of Facility DWs, Helfenbein & Newnam Funeral Home Fellows, 130 Speer Rd. Chestertown, MD 21620 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Mat Physician disease or condition resulting in death) /Medical or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last au-otially list conditions equence of) Examiner The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death Month Day 5 ☐ Other (specify) 1 □Yes 2 □No 9 Unknown 9 I Inknown 23e. Did tohacco use contribute to the cause of death? significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 No 1 □Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signatu 0 and address of person who completed cause of death (Item 239 (Type, Print) + 31. Date filed (Month, Day, 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 8:05A Physician/ hdul Man Saray Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Baltimore County Randallstown Northwest Hospital 9. Birthplace (State or Foreign Country Leone, Sierra Leone, 8. Date of Birth (Month, Day, Year) 953
December 2, If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 **X** M 2 □ F Months Days Hours 56 212-69-3997 **Director** Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b County by Funeral Director 1 X Yes 2 No **Baltimore** Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Freetown, Sierra Leone, West Africa 21216 4736 Wakefield Road; Apt. 201 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 🗶 No If Yes, Give 1 Never Married 2 X Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education Sears, Roebuck & Co. Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Department Stores Technician vears Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Posseh Kamara 2 Chico Foday Mansaray 19a. Informant's Name/Relationship (Type, Print)
Ramatu Bangura (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once, 18545 Eagles Roost Drive; Germantown, Maryland 20874 Foday Chico Mansaray (Son) Date 21,2010 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Maryland National Memorial Park | Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility R. N. Horton Company Morticians Signature of Funeral Service Lice Inc.;600 Kennedy Street, N.W.; Washington, D.C. 2001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Hepatocellular (ancer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a consequence of) Examine if any, leading to immediate cause. Litter Underlying Cause (Disease or linjury that the death certificate be executed ending physician and use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Year in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed Were autopsy findings available prior to completion of cause of 24a Was an autopsy performed? Yes 2X No death? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) æ in-fattent hospice examiner? Hospital: Other: 2 1 No 6 V Other (Sp 1 🗌 Yes ☐ Nursing Home 5 ☐ Residence 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 27. Manner of Death Certificate: Natural 5 Pendina 1 🗌 Yes 2 🗌 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 4/7/10 DOUS7 465 715 Ratipalise M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 203 -Baltimore, MD. 21209 N 5 Rajapakse, M.D 2835 Smith AV., 31. Date filed (Month, Day, Year) 32. Registrar Signatu State

DHMH 17 Rev 7/2009

Registrar

APR 1 6 2010

14479

		•	State Registrar	,	Cer	tificate of L	Death		Reg. No.		
	Physicia	n/	1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	Year	3. Time of Death
	Medic		Jesse A. Norm					ים ייים	4/14/20		51 00
	Examin	er	4a. Facility Name (if not institution, give str				r Location of Death Pr Spring			ty of Death Intgom	arv.
	Funeral		Holy Cross Hospita 5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birtl	h		lace (State or Foreign
	Director		237-48-5696	M 2 □ F 75	Yrs.	Months Days	Hours Min.	o27257	1935	Count	NC NC
	ld now	_	Usual Residence of Decedent 10a. State 10b. County	10c. City.	Town or Loc	eation				10	Od. Inside City Limits
	arylar a-fst ified	Director	MD Prince Ge			stville					1XYes 2 □ No
	or 28 e not	١	10e. Street and Number	eorges	_1 01 6	10f. Zip Code			10g. Citizen o	f What Coun	try?
	s 23a	Funeral	7807 Anny Dr.				20747				AZU
	death r item ner n		T T T T T T T T T T T T T T T T T T T	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No	13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Spann, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ice - America ack, White, e	
38	al", o	Completed by	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1	1	☐ Yes 2XNo	Specify:		Specia		
<u>0</u>	hours natur dical	lete	15. Decedent's Educ (Specify only highest grade	cation	16a. Deced	lent's Usual Occup	ation during most of work		16b. Kind of		
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5	ed wit Hygie other	BeC	17. Father's Name (First, Middle, Last)		Heavy	Equipmen	nt_Operat 18. Mother's Nam			<u>ation</u>	
au	be file ental rked c	횬	Jesse Norman			:		Mae Rai		116)	
ary	hould and M is mai		19a. Informant's Name/Relationship (Type		19b. Mailin	g Address (Street a	and Number or Run	al Route Number	; City or Town,	State, Zip C	ode)
Σ.	nd 2 s ealth m 27		Dorothy E. Norman			Anny Dr	Forest	ville	אט כטיי	 	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatte event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ R	amount from State Cei	meterv. cren	sition (Name of natory or other plac	e) !	Date	20c. Location	•	
凯	artmer artmer ortant injury		4 ☐ Dopation 5 ☐ Other (Specify) 21. Signative of Funeral Sey ice Licenses	Harm		. Name and Addres	Cem : 04/2		Landov		
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	llysician,	8 8	Immediate Cause (Final disease or condition	CHF							Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a conseque							
		er	Sequentially list conditions, if any, leading to immediate	Hypotensior Due to (or as a conseque						-	
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8760	Hospital or Attending Physician: The law requires that the death certificate be executed 24 burus after death. Funeral Director: After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	d.								
687	ertifica ding p	-	IF FEMALE:	c. If ves. outcome of pregnan	cv				2015		
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B	requires that the death cer been signed by the attendii should be detached for use	Physician/	g Unknown	g 🗌 Unknown							
P.O.	s that gned be det	þ	Part II. Other significant conditions cont	ributing to death but not resul	lting in the u	nderlying cause giv	en in Part I.				e cause of death?
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Division of Vital Records,	lor At after d Direc	Cerl	4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ie, farm, stre	ет, тастогу, опісе		28f. Location (S: City or Town		ber or Rural i	Route Number,
	ospita hours ineral d fillec	Medical	29a. Certifier 1 Certifying Physic	ian: To the best of my knowle	dge, death o	ccured at the time	, date and place, ar	nd due to the cau	use(s) and man	ner as stated	i.
	To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completed filled in by the funeral di	Mec	only one) 3 Certifying Nurse	r: On the basis of examination a Practioner: To the best of my l		eath occurred at the	e time, date and plac				
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	LL		30. Name and address of person who con	Inlated cause of do-th (three)	220) (5:	TD P3F	200		-	9/2010	J
4	\mathcal{V}^{T}		Dr. Pothu Nagabhur		t Gle	n Rd. Si	lver Spr	ing, MD	20910		
	Stat	3.5	31. Date filed (Month, Day, Year) APR 2 7 2010	32. Registrar's Signatu	re						
	Registra	ar	APHZ (7010 ZZ	were by. He							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ O'Connor Joseph T. April 2010 10:15 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1532 Lowell Ct. Crofton Anne Arundel . Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🔀 M 2 🗆 F Months Hours Min. OCt. 28 Year) 921 Country Maryland 578-22-9097 88 Director Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director MD Anne Arundel Crofton 1 Tes 2 No 10e. Street and Number 0 10f Zip Code 10g. Citizen of What Country? Funeral 23a 1532 Lowell Ct. 21114 United States should be filed within 72 hours after death w and Mental Hygiene. is marked other than "natural", or items ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 XYes 2 No
If Yes, Give Black, White, etc 2 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. WWII Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Land Surveyor Surveying Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gregory A. O'Connor Mary Ellen Dady 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sh it of Health a If item 27 is Marjorie Platt O'Connor/Wife 1532 Lowell Ct., Crofton, MD 21114 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Our Lady of the Fields 04/24/2010 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 and Department of H 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) any injury or Millersville, MD mportant 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) nding physician Physician/Medical that the death certificate be Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death signed by the at d be detached fo P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an าสร autopsy performed? Yes 2 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 164LVA AGE GREE

Registrar

31. Date filed (Month, Day, Year)

NAR

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Day **Physician** 223 M D alcula VEDUM ZUIV /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel 808 Cedarcroft Dr. Millersville If Under 24 Hrs. Date of Birth (Month, Day, Year) 4/3/1949 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Min. Months 1**X** M 2 □ F Davs Hours 219-54-6479 61 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Lection Examinating the profitted at I∏Yes ▼ No Director Millersville MD Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 808 Cedarcroft Dr. 21108 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. ^{2□No}Vietnam 1 ☐ Never Married 3 ☐ Married 1. □Yes 2 □ If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify Specify ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) US Government Electrician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Purdum Elizabeth Hayes ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other troops. Millersville, MD 21108 Beatriz Purdum Wife 808 Cedarcroft Dr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 4/20/2010 Glen Burnie, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Sérvice Licenses Dal Annapolis, MD 21401 12 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician - 0 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): sician and burial-transit certificate be executed Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 2 No icate has been sig 7, page 2 should b 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy performe certificate 1 ☐Yes 2 ☐No Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗷 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

To the I within 2

31. Date filed (Month, Day, Year) APR 2 1 2010 Registrar

29b. Signature and title of certifier

1,1150

29a. Certifier

(Check only one)

Medical

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year) 8

dew 11+1

Registrar
DHMH 17 Rev 1/2001

State

100 Hospiteul

32. Registrar Signature

Geneva

Prince Frederickimo 28678

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

Mitchell

Douglas

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 24a & 25 per med cert G907 97 16/10 dk

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death April 14, 2010 **Physician** 10:00 P Tracie Lorraine Papp /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Clinton Clinton Nursing Home 8. Date of Birth Month, Day, Oct 17, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 ☐ F 92 Texas 077 14 1355 Director Usual Residence of Decedent r 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Prince George's Temple Hills Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or traumatic event, the Medical Examiner must be 5691 Old Temple Hill Road 20748 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify. Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) than Maryland Public Schools Cafateria Manager permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygic Important: If item 27 is marked other if any injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Randoff Saunders Walker | Tracy Jessie ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5691 Old Temple Hills Road, Temple Hills, MD 20748 Tracie Saunders-Papp (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Lee Crematory April 24, 2010 Clinton, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee mo1533 22. Name and Address of FacilityLee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest on each line. Immediate Cause (Final disease or condition resulting in death) condiac avin //m/cos Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Sauce deals Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autopsy performed?

1 Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA To this 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Pospital or Attending P 24 hours after death. Funeral Director: After t After t Certification: 1 Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00025640 4/17/10) curry

31. Date filed (Month, Day, Year) State Registrar

Khosrow Davachi, M.D. 7801 Old Branch Ave #409, Clinton, Maryland 20735 32. Fegistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ Month 9 April 11:50 P M Lula M. Pelham Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Forestville

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 1913 Prince George's Forestville Health & Rehabilitation 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** South Carolina 1 🗆 M 2 🔀 F Director 579-54-9315 Usual Residence of Decedent ems 23a or 28a-f show r must be notified at 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 X Yes 2 No Forestville Maryland Prince George's 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20747 7806 Anny Drive United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Deces Armed Forces? ✓ Ves 2 🔼 No 11. Marital Status 12. Was Decedent Ever in U.S. ral", or iten Black, White, etc. 1 Never Married 2 Married Completed by within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎽 No Specify: Black. "natural", Specify: 3 X Widowed 4 Divorced Year or Dates th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical I 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8th Domestic Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filt Derartment of Health and Mental I Important: If Item 27 is marked c any injury or other traumatic eve once. ည Amanda Elmore William Hamilton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7806 Anny Drive Forestville, Maryland Barbara J. Marrow/ Daughter 20747 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery crematory of Harmony Park April 16. 1 X Burial 2 Cremation 3 Removal from State ☐ Donation 5 ☐ Other (Specify) Landover, Maryland Memorial ture of Funeral Service Liden 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Rd. NE Washington, DC 23a. P 11 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, she's, a heart failure. List only one cause on each line. Interval Between A dvanced Immediate Cause (Final Dementia Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year signed by the at d be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cardiopulmunary Failure Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 2 X No ٩ 1 Tyes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of e Hospital or Attending Pl n 24 hours after death. e Funeral Director, After tl Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 51520

State Registrar

DHMH 17 Rev 7/2009

1328 Southern Ave. Suite 310 Washington, DC

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Bahram Pishdad, MD
31. Date filed (Month, Day, Year)

6 2010

10-03205 Daryl Revelle R	edcı		ck Indelible Ink. Ensure All Copic Department of Health and Mental H Certificate of Death	es Are Legible. lygiene 2010	1448
Physic Medical Exam		Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year	3. Time of Death 1745 hrs
Medical Exam	III	Daryl R. Redcross 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	April 25, 2010 4c. County of Deat	
		11211 Tippett Road	Clinton	Prince Georg	e's
Funeral Director		577-88-1494 1XM 2 F 44	In yrs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min		rthplace (State or gn DC puntry)
any		Usual Residence of Decedent 10a. State 10b. County 10	Oc. City, Town or Location		10d. Inside City Limits
*	ō	Md Prince George	Temple Hills		1 X Yes 2 No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show a injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 4106 22nd Ave	10f. Zip Code 20748	10g. Citizen of What Cou USA	ntry?
ath with	Funeral	11. Marital Status 1 X Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerto		rican Indian, Black,
after de	y Fu	1 Yes 2 X 3 Widowed 4 Divorced If Yes, Give Year or Dates:	No 1 Yes 2 X No specify:	Specify: Bla	ack
hours :	ted t	15. Decedent's Education (Specify only highest grade compl	during most of working life, DO NOT use reti		Industry
036 rithin 72 sne. r than *	Completed by	Elementary/Secondary (0-12) College (1-4 or 5+) 1 year	Laborer	Pvt Indu:	stry
15-0 filed w Il Hygie ed othe	e Co	17. Father's Name (First, Middle, Last) Harold Redcross	18.Mother's Name Brenda	e (First, Middle, Maiden Surname)	
212 vuld be Menta marke	То Ве	19a. Informant's Name/Relationship (Type, Print Mothe		_	a, Zip Code)
MD d 2 sho If th and in 27 is		Brenda Taylor Skipwith	3101 Elizabeth Ida		
of Heal		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or	·
timent trment rtant:		4 Dopation 5 Other Specify:	Riverdale Pk Crem 20	1017702011	e,Maryland
Bal permi Depar Impo injur		21. Signature of Fundral Service Licena	22. Name and Address of Facility Tyrone J. Young	719 Kennedy St	20011 .NW WashDO
Physician		23a. Part I. Pher the disease, or complication had caused the failure. List only one cause on each line.			Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a. Hemoperican			Death
		or condition resulting in death) Due to (or as a consequence Ruptured a	^{lence of):} A ortic dissection		
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause			
	xaminer	(Disease or injury that initiated events resulting in death) Last	ence of):		
executed in and il - transi	ш	d			
O, e be ex /sician burial	edic	X UNPENDED AMENDED Pi line a-	-b, 27, per ME G904 6/1/10	TT	
68760, certificate be nding physici	M/us	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome 1 Live birth	of pregnancy 2 Fetal death 3 Ectopic pregna	23d. Date of deliver	y Day Year
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transi	Physician/Medical	1 Yes 2 No 9 Unknown 19 Unknown	ne of death 5 Other (Specify)		
Records, P.O. Box The law requires that the death cate has been signed by the atte page 2 should be detached for u		Part II. Other significant conditions contributing to death be	ut not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to	the cause of death?
S, P. nires th signed d be de	ed by			1 Yes 2 No 3 Prol	pably 4 V Unknown
ords sw requ as beer	Completed			autopsy prior to d	topsy findings available completion of cause of
Rec The la icate h	Com			performed? death? 1 ✓ Yes 2 No 1 ✓ Yes	es 2 No
ital ician: s certif	Be	25. Was case referred to medical examiner? 1 Vos. 2 No. Hospital: 1 Inpatient	26.Place of Death (Check of De	only one) g Home 5 Residence 6 🗸 Othe	S Sanna
of V g Phys fter thi	<u>٦</u>	27. Manner of Death 28a. Date of Injury	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred	. Scerie
ion tendin eath.	ation	1 X Natural 5 Pending 2 Accident Investigation (Month, Day, Year)	1 Yes 2 No		
Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Certification:	3 Suicide 6 Could not be determined (Specify)	/ - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Ru or Town, State)	ral Route Number, City
Hospit 24 hour Funer:		29a. Certifier 1 Certifying Physician: To the best of my kr (Check only	nowledge, death occurred at the time, date and place, and		
To the within To the	Medical	one) 2 Medical Examiner: On the basis of examin and manner stated. 29b. Signature and title of certifier	ation and/or investigation, in my opinion, death occurred a 29c. License number	t the time, date and place, and due to th	
	-		200. 200		, 20,, . 001/

State 31. Date filed (Month, Day, Year) Registrar NAY 0 4 2010

Assistant Medical Examiner

32. Registrar's Signature

Theodon W. Hire The me 30. Name and address of person who completed calle of death (Item 23a)

Theodore M. King, Jr., MD.

OCME

April 26, 2010

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Year Physician/ April 21, Mario Nelson Romero 0250 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Holy Cross Hospital Silver Spring 5. Social Security Number 7. Age (In yrs. last birthday) 38 yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 589-50-9205 Days Hours Min. (Month, Day, Year, 1971 Bolivia Sept Director Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director notified 28a-f MD Montgomery Silver Spring 1 Tyes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral 3733 Ferrara Drive 20906 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian "natural", or ite Black, White, etc. Never Married 2 Married ģ 2 X No Yes Maryland 21215-0036 1 X Yes 2 ☐ No Specify: If Yes, Give Year or Dates Bolivian White Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Wholesale Tobacco Elementary/Seconday (0-12) College (1-4 or 5+) Manager and Groceries Ith and Mental Hygien 27 is marked other the traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Teresa Rosario Orihuela Mario Rafael Romero 19a. Informant's Name/Relationship (Type, Print) Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Teresa Rosario Orihuela 3733 Ferrara Drive Silver Spring, MD 20906 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Cementerio General 4-29-10 Cochabamba, Bolivia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Metropolitan Funeral Service Signature of Funeral Service Licensee 5517 Vine St. Alexandria, VA 22310 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Hypovolemia Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Hyperglycemia Sequentially list conditions, if any, leading to immediate cause. Enter underlying Due to (or as a consequence of) Examir Cause (Disease or linjury that initiated events Diabetes requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Leukemia Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy ate has been signed by the atter page 2 should be detached for u in the past 12 months? Day Month Year 5 Other (specify) Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4x Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? ☐ Yes 2 🗌 No 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) 1 ☐ Yes 2 ♣ No Other: ဂ္ 1 Main Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: I or Attending F s after death. 5 Pending Natural 1 Yes Accident
Suicide Investigation 6 Could not be 2 🗌 No Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and tit 29d. Date signed (Month, Day, Year) April 21, 2010

Registrar DHMH 17 Rev 7/2009

State

32. Registra s Sign

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Richard Nguyen, MD 1500 Forest Glen Dr. Silver Spring, MD 20910

Richard Nguyen, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 4 2010 SSELLO JHUN Medical a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 1**Д** М 2 □ F Months Days Hours Min. New York Director 30-24-7991 78 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho dical Examiner must be notified at Director Annapolis Maryland| Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21401 USA 860 Boatswain Way Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 1 Yes 2 No
If Yes, Give
Year or Dates.1955-63 Black, White, etc. ð 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Electrician Construction 12th other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked o permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked c any injury or other traumatic eve once. မ Joseph Rossello Grace Ruffino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 860 Boatswain Way, Annapolis, MD 21401 Adele Rossello/ Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State MD Veterans Cemetery 4/26/10 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ervice (censee 21. Signatur 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory agrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death signed by the a Id be detached f g 🗌 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 1 Yes 2 No Yes Division of Vital completed filled in by the funeral director, Be Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 Natural 28d. Describe how injury occurred injury work? 5 Pending 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier 1 📈 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cenfie

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate

1 ☐ Yes 2 No

Registrar

ENSE HIGHWAY

ame and address of person who completed cause of death (Item 23a) (Type, Print

1CH ARL 31. Date filed (Month, Day, Year, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ruce Wayne R	eev	es S 1- For State Registrar	tate of Maryla		artment o		nd Men	ital Hyg		eg. No.	201	0 1448
Physici ledical Exam		1. Decedent's Name (First, Midd							Date of Dear Month April 24, 2	th Day	Year	3. Time of Death 1015 hrs
		4a. Facility Name (if not institution Black Bottom Road	on, give street and nu	mber)		4b. City, Town, o	or Location o	of Death		4c. Co Ker	ounty of Dea	ath
Funeral Director		5. Social Security Number 212-70-0043	6. Sex	7. Age (In yrs.	last birthday) 55 Yrs	If Under 1 Ye Months Da			8. Date of Bir		Fore	Birthplace (State or eign Country) CA
i iow any		Usual Residence of Decedent 10a. State 10b. County		1	, Town or Locat	ion						10d. Inside City Limits 1 Yes 2 No
ith the Maryland 23a or 28a-f show notified at once.	Director	MD Ceci 10e. Street and Number 10 Barksdale	_	EI	kton	10f. Zip Code 21921	_		11	0g. Citizen USA	of What Co	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 M	12. Was Dec	2 X No		s Decedent of H es, specify Cuba						erican Indian, Black,
2 hours after "natural",	Š	3 Widowed 4 Div 15. Decedent's Education (Spe Elementary/Secondary (0-12)		e completed)	16a. Deceden	Yes 2 X Notes Note Note Notes 1 Notes Note Notes	ation (Give I	kind of work	k done)		ecify: Wh:	
215-0036 be filed within 72 hours after nital Hygiene. rked other than "natural", ent, the Medical Examiner	Completed	11 17. Father's Name (First, Middle			Job Su	perinte		's Name (Fi	irst, Middle, N		name)	tion
2121! hould be fill nd Mental H is marked atic event, t	To Be	Glen Phillip R	ship (Type, Print)		7	Address (Stre	et and Num	nber or Rura		ber, City o	r Town, Stat	te, Zip Code)
imore, MD 2121 Pages 1 and 2 should be filment of Health and Mental 1 tant: If item 27 is marked or other traumatic event,		Lynn Reeves/ W 20a. Method of Disposition 1 X Burial 2 Cremation				rksdale ition (Name of ce ner place)		D	ate			or Town, State
Baltimore, permit. Pages 1 an Department of Hea Important: If iter		Donation 5 Other S	pecify:	Un	ion Cem	etery ame and Addres	s of Facility	IX . I	Foar	d and		MD on, MD 21921
Physician /Medi l Examiner		23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease	on each line.			e mode of dying	, such as ca	ardiac or re	spiratory arre	est, shock,	or heart	Approximate Interval Between Onset and Death
	ner	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a b. Due to (or as a									
cuted nd transit	I Examiner	(Disease or hijury that initiated events resulting in death) Last	Due to (or as a d	consequence o	of):		•					
68760, certificate be executed nding physician and se as the burial - transi	/Medical	UNPENDED IF FEMALE: 23b. Was decedent pregnant in the	AMENDED 23c. If yes, o	utcome of preg							ate of delive	
Records, P.O. Box 6876(The law requires that the death certificate cate has been signed by the attending physpage 2 should be detached for use as the b	Physician/Me		4 Pregna	ent at time of de wn	eath 5 Oth	al death 3 ner (S <i>pecify)</i>		pregnancy		Mor		Day Year
S, P.O. uires that the signed by Id be detach	à	Part II. Other significant condit	ions contributing to	death but not r	esulting in the u	nderlying cause	given in Pa	rt I.	1 Yes	2 🗸 No	3 Pro	
Division of Vital Records, ral or Attending Physician: The law requir rs after death. al Director: After this certificate has been sted in by the funeral director, page 2 should be	Completed				-			_	24a. Was a autops perform	sy med?		utopsy findings available completion of cause of
f Vital Re Physician: The er this certificate ral director, page	To Be	25. Was case referred to medica examiner? 1 ✓ Yes 2 No 27. Manner of Death	Ulaspital:	patient 2	ER/Outpatient	3 DOA		Check only Nursing He			6 Othe	er: Scene
Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifiely filled in by the funeral director.	Certification:	1 Natural 5 Pend 2 Accident Inves	found: Stigation FOUND: Apr 24, 2	Day,Year) 010	FOUND: 1015 hrs		Yes 2	No Sui	bject shot	self		ural Route Number, City
Hospi 24 hou Funer tely fil		4 Homicide deter	d not be (Specify)	Dirt Parkin		ed at the time, d	ate and plac	Bla	or Town, St ck Bottom F	ate) Road, Ma	ssey, MD)
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Example 29b. Signature and title of certifie	miner: On the basis of and manner sta er		nd/or investigati	29c. Licens	se number	curred at the	e time, date a			ne cause(s) onth, Day, Year)
	ż	30. Name and address of person				O.C.			14054	April 25	5, 2010	
St Regist	~,,,	Donna M. Vincenti, MI 31. Date filed (Month, Day, Year)	32. Reg	edical Exan		Penn Street	, Baltímo	ore, MD 2	21201			
DHMH 17 Rev 1/20	_	APR 27	CUIU Den	ww /s	ORIGINAL							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For AMEND#7 per FH State of Maryland State of Maryland Registrar 4/20/2010 AACO HEALTH DEPT. OM Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Rhoda C. Rugo ^{Day} 201<u>0</u> Physician/ April 17, 8:00 Αм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Numbe Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 216-22-3316 Days Country)Maryland 1 🗆 M 2 🖹 F 79-84 Months Hours 8498th 1925 Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Maryland Anne Arundel 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. fitem 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits Annapolis 1 🌠 Yes 2 🗌 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 36 Southgate Avenue 21401 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. \$ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Executive Assistant State of Maryland Be 17. Father's Name (First, Middle, Last)
Robert C. Cook 18. Mother's Name (First, Middle, Maiden Surname)
Eleanor Higgins ည permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $36\ \, ext{Southgate Avenue, Annapolis, MD 21401}$ 19a. Informant's Name/Relationship (Type, Print) Terry Harris - Daughter Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Baltimore Crematory 1 Durial 2 Cremation 3 Removal from State 4/21/2010 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home . Signature of Funeral Service Licensee Mychini. Wolo 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final pset and Death Physiciani disease or condition Medical resulting in death) as a consequence of) Examiner Sequentially list conditions, if any, is a limited of the cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innertal Innertal price 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Year 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital Other: မြ 1X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the best of examination and/available time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and tit ertifie 29d. Date signed (Month, Day, Year) Name and address of per on who completed cause of death (Jem 23a) (Type, Print) fense thry, crofton, mo mp PZ avl 31. Date filed (Month, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 04 07:35A M Veronica Joan Smith Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death LISbun Wicomico pastal Hospice If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 🗆 M 2 🏋 F 05 29 11923 218-16-7276 Director 86 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 No Salisbury Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21801 USA 200 Civic Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Montgomery Wards Sales Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bernadine Harvey Joseph Lappin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31955 Pembroke Court, Delmar, MD 21875 William Smith III, Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 K Burial 2 Cremation 3 Removal from State any injury or 4 24 2010 4 Donation 5 Other (Specify) Parsons Cemetery Salisbury, MD Fue IS vio Licensee 22. Name and Address of Facility Holloway Funeral Home P.A. Chompson CFSP 501 Snow Hill Rd., Saisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ CERRBROVASCULAR ACCIDENT disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** LNSUFFICIRNO ACUTIZ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or finjury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 2/1 No Other: 1 🗆 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 112 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be completed filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗔 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien@ Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Joseph April 20 2010 /Medical Shorter ĥа 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Washington Rehabilitation Washington 1 Year | If Under 24 Hrs. Prince Georges 8. Date of Birth (Month, Day, Year) 4/18/1918 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days 1**☑**M 2□F Yrs 92 Director 230-09-0562 Wash. DC Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow item 27 is marked other than "natural", or Items 23e or 28a-f abov other traumetic event, the Mudical Examinar must be notified at 1 √Yes 2 No Director Bladensburg 10f. Zip Code P.G. 10e. Street and Number 10g. Citizen of What Country? 4202 58th Ave#214 Funeral 20710 S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Item any injury or other traumetic event, the Medical Evernmenting. Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 ·by 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Electrical Engineer Tech Census
18. Mother's Name (First, Middle, Maiden Sumame) Census Bureau 17. Father's Name (First, Middle, Last) Be ္ William Shorter Julia Mason 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adrian Shorter wife 4202 58th Ave #214 Bladersburg MD 207 e of Disposition (Name of Date 20c. Location City or Town, State 20710 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Crem. 4/23/10 Riverdale, MD. 22. Name and Address of Facility Hodges and Edwards 21. Signature of Funeral Service Licensee 3910 Silver Hill RD.Suitland MD 20746 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Prosician Advance Colon Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 attending physician Physician/Medical as the IF FEMALE esп 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Cher (specify) 1 ☐ Yes 2 ☐ No Records, P.O. the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Anemia Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Dementia autopsy performed? 1 Yes 2□ No 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Varing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: To the Hospitel or Attending within 24 hours after death.
To the Funeral Director: After 5 Pending investigation Injury Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗀 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and tipe of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20 2010

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of rersor

APR 2 6 2010

12017 Ft. Washington Rd Ft. Wash.MD

who completed cause of death (Item 23a) (Type, Print)

32: Registrar's Signature

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Physici Medical Exami						Day Year	1805 hrs
		4a. Facility Name (if not institution, give street and number) Baltimore Washington Medical Center	4b. City, Town, o	or Location of Death		4c. County of Death Anne Arundel	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Ye	ear If Under 24Hrs.	8. Date of Birth	n(MM/DD/YYYY) 9. Bin	
Director		218-76-2163 1X M 2 F 52 51 Yrs	Months Da	ys Hours Min.	3/3/19.	58 Foreig	in untry) MD
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Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and Iv Important: If item 27 is m injury or other traumatic.			lame and Addres	ss of Facility	·		
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876 tificate ng phy as the	an/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fet	tal death 3	Ectopic pregnar	псу	23d. Date of delivery Month D	ay Year
Box 68760, death certificate be exthe attending physician defor use as the burial	٠:5 I	4 Pregnant at time of death 5 Oth	her (Specify)			ľ	
the de ched fi	Physi	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause	given in Part I.	23e. Did tob	acco use contribute to t	the cause of death?
of Vital Records, P.O. ag Physician: The law requires that the offer this certificate has been signed by ineral director, page 2 should be detach	à				1 Yes	2 No 3 Prob	ably 4 🗸 Unknown
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eco he law ite has	ompleted				perform	ed? death?	
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n of ding Ph h. After t		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Ir		ury at Work?	28d. Describe ho	w injury occurred	
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To the within To the comple	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigati and manner stated.					
	Σ	29b. Signature and title of certifier	29c. Licens	se number .M.E.		29d. Date signed <i>(Mor.</i> April 30 , 2010	th, Day, Year)
AH		20 Name and address of source the source of	0.0.	. IVI . L.,		, pili 50, 2010	
2		Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner	treet, Baltim	ore, MD 21201			
St	ate	31 Date filed /Modiff Day Vehrer 0.04.0 32 Registrar's Signature					<u>-</u>
Regist	FO F	MINIO VOLUTO LENGUA A. ME	Mes				

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend#2perfuneralhome4/27/16erificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JOHN 2010 STEWAK 8:20 AM April /Medical 4a. Facility Name (If not institution, give street and number) County of Death Examiner 4b. City, Town, or Location of Death Regional HOSPITA rince George's aure 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1 Months Days 1 ₩ M 2 □ F Hours 272-16-1737 92 Director 10-13-1913 Roanoke, VA Usual Residence of Decedent 10a. State 10b. Counts 10c. City. Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Evaniner is ust be notliked at Director MD 1 Yes 2 □ No Prince George' Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9001 Cherry Lane 20708 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: by Specify: Black 3 □ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygient Important: If item 27 is marked other tha any Injury or other traumatic event, ITM ODGE. 12th Cook & Chaplin Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rev. John H. Stewart 2 Ida Vaughan 19a. Informant's Name/Relationship (Type. Prorand 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter 1724 Carriage Lamp Ct. Severn, MD 21144 Michelle Jenkins, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State 4-24-2010 Petersburgh, VA 4 ☐ Donation 5 ☐ Other (Specify) Blandford Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility William N. Bland &Son mbuly 137 Harrison Street Petersburgh, VA 23803 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Aspiration eumonia disease or condition resulting in death) /Medical Due to (r as a consequence of): Examiner Seizures Sequentially list conditions, Examiner trans, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last residuence of Hospital or Attending Physician: The law requires that the death certificate be executed Failure 10 and burial-tran Due to (or as a consequence of) attending physician Physician/Medical the as IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) the 1 ☐Yes 2 ☐No 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ▼No 24a. Was an has autopsy certificate 2 **X**No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 1 Yes 2 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my pinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Division of Vital Records, P.O. Box 68760, 24 hours after death Funeral Director: within 2

State

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month. Year

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certifie

Malik

29b. Signature and

32. Registrar's Signature

Regiona Hospital Laurel

ORIGINAL

29c. License number

D66284

7300

Laure

usen

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ 853M Kenneth Harold Smith Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death 4b. City, Town, or Location of Death Washington County Hospital Hagers town Washington county . Social Security Number Funeral 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 067-18-9079 Hours Min. July 30, 1924 New York Director 85 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked outher than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington County Williamsport 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 16505 Virginia Ave. 21795 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 ☐ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Educator Board of Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank E. Smith Sylvia Southworth Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Brill-daughter 16 St. Paul St. Boonsboro, MD 21713 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory 4-29-2010 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Si nature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home 331 Fastern Blvd. North Hagerstown. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last or as a consequence of) certificate has been signed by the attending physician irector, page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 K Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 🗆 ER/Outpatient 3 DOA 28c. Injury at work?
___1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) SH STI State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 18, 2010 Year Marybeth H. Stoll 5:15 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months 06/04/1947 Pennsylvania 166-40-9360 1 □ M 2 🗓 F Hours Director 62 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Yes 2 No Maryland | <u>Anne Arundel</u> Harwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 290 Princes Lane 20776 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Completed by Black, White, etc. 1 ☐ Never Married 2 🔀 Married 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Elementary School 5+ years Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Denis O'Donnell Emma Reese 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barry T. Stoll/ Husband 290 Princes Lane, Harwood, MD 20776 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State cemetery, crematory or other place) Kalas Crematory 4/20/10 Edgewater, MD 4 ☐ Donation 5 ☐ Other (Specify) ervi Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Sheet and De Physician Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and I for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown been signed by the atter should be detached for i Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has k completed filled in by the funeral director, page 2 s autopsy 2 2 XNo 1 Yes ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 No 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 욘 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? Natural 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatu 29c. License number ause of death (Item 23a) (Type, Print) 300 BESTURY Annaporis UD 2140!

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Monti

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State of Maryland / Department of Health and Mental Hygiene

		1- For State Certifica Registrar	te of Death	Reg.	No. 2010	4498
Physic Medical Exam		Decedent's Name (First, Middle, Last)		2. Date of Death Month	ay Year	3. Time of Death
iviedicai Exam	mer	Keith Stansbury 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea	April 23, 201	10 4c. County of Death	1944 hrs
		Clay Hill Road & St. Margarets Road	Annapolis		Anne Arundel	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth			MM/DD/YYYY) 9. Bird	
Director		218-52-9301 1XM 2 F 5	Yrs. Months Days Hours M	in. Mar 24	l-1959 68	n amyland
ź.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of	ir Location			10d. Inside City Limits
D P		Maryland Anne Arundel Anna				1 Yes 2 X No
Maryland 28a-f show any 1 at once.	Director	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Cour	
the M sa or 2	Dire	1255 Stonewood Ct.	21409		USA	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ten of Health and Mental Hygene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 XNever Married 2 Married Armed Forces?	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer		14. Race - Ameri White, etc.	can Indian, Black,
er deal	_	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 No specify:	,		ack
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6 72 ho m "na cal Ex	lete	Elementary/Secondary (0-12) College (1-4 or 5+)	uring most of working life. DO NOT use re	etired)		
003(within jene. Media	Completed	6th 0	None		None	
21215-0036 uld be filed within 72 hours al Mental Hygiene, marked other than "natural e event, the Medical Examin	Be Co	17. Father's Name (First, Middle, Last) Hilton R. Stansbury Sr		ne (First, Middle, Mai	49	
212 212 2uld be 1 Ment mark	To B		Mailing Address (Street and Number o			Zip Code)
MD d 2 shou lith and n 27 is numatic		Stephanie V. Stansbury(Sister				
Baltimore, MD permit. Pages 1 and 2 sho Department of Health and Important: If item 27 is injury or other traumati		20a. Method of Disposition 20b. Place of Method of Disposition 20b. Place of Method of Disposition 20b. Place of Method of Disposition	Disposition (Name of cemetery, you achier where Y	i	Oc. Location - City or	
LimC. Page ment tant:		4 Donation 5 Other Specify:			Arnold,	
Ball permit Depart Impor		21. Signature of Funeral Service Licensee	22 Walne an R 20 S & Fallity S C 821 West St. A			
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not	1			Approximate Interval
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a Drowning				Between Onset and Death
LXaiiiiiei		or condition resulting in death) Due to (or as a consequence of):				
	ē	Sequentially list conditions, if any, leading to immediate b		•		
	Examiner	cause. Enter Underlying Cause (Ciscose or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
nd sd ransit		events resulting in death) Last Due to (or as a consequence of): d.				
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Box 687 e death certific the attending p	ciar	past 12 months? 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregr	nancy	Month D	ay Year
BO)	Physician/	1 Yes 2 No 9 Unknown 9 Unknown		,		
res that the signed by.	by P	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.		cco use contribute to t	
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Division of Vital Records, ral or Attending Physician: The law requir is after death. **I Director: After this certificate has been silted in by the funeral director, page 2 should be	Completed			autopsy performe	d? death?	empletion of cause of
tal Recician: The l		25. Was case referred to medical	26.Place of Death (Check		No 1 ✓ Yes	2 No
Vita nysicia this ce	o Be	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 ER/Out	Othor		sidence 6 🗸 Other:	Scene
n of ing Pi After funera	Ë	1 Netural (Month, Day, Year)	me of Injury 28c. Injury at Work?	28d. Describe how		
Sior Attence death ector: by the	catio	2 X Accident Investigation Fd 4/23/10 Fd 7	7:44 pm 1 Yes 2 X No	subject		t Day to March and City
Divi	Certification	3 Suicide 6 Could not be determined (Specify) Found: in		or Town, State	et and Number of Rur e) Clay Hill c Rd Annapo	Rd & St.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be excepted within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	n occurred at the time, date and place, an			
To the within To the Comple	Medical	one) 2 Medical Examiner: On the basis of examination and/or invand manner stated.				
	Σ	29b. Signature and title of certifier	29c. License number		ed. Date signed (Mon	h, Day, Year)
			O.C.M.E.		April 24, 2010	
		 Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn 	Street, Baltimore, MD 21201			
	ate	31. Date filed (Month, Day, Year) APR 3 0 2010 32. Registrar's Signature	back			
Regis	2 7 4 7	MURUUU (UIU / b assa . M	OR CARLO			1

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State of Maryland / Department of Health and Mental I	Hygiene 🥠	010	1449	-1
Certificate of Death	Reg. No.	UII	1 4 4 7	1
Middle,Last)	2. Date of Death		3. Time of Death	1

		1- For State Cert	ificate of Death	Reg	. No.	0 4447	
Physic		Decedent's Name (First, Middle,Last)	First, Middle,Last)				
Medical Exam	iner	- INCENTIFIC DODINGE					
		Facility Name (if not institution, give street and number) S17 Baltic Avenue	4b. City, Town, or Location of Death Baltimore		4c. County of Death		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	t birthday) If Under 1 Year If Under 24Hrs	. 8. Date of Birth	(MM/DD/YYYY) 9. Birt	hplace (State or	
Director	1	578-66-7302 1 _{XM} 2 _F 59	Yrs. Months Days Hours Min.	09/28/	1950 Foreig	n Maryland	
		Usual Residence of Decedent					
/ any			own or Location			10d. Inside City Limits	
and show	5	MD				1 X Yes 2 No	
daryland 28a-f show 1.at once.	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Cour	itry?	
death with the Maryland or items 23a or 28a-f sho must be notified at once.		517 Baltic Avenue	21 225		USA		
with ms 23 be no	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.		ecify Yes or No-	14. Race - Ameri	can Indian, Black,	
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115. e filec al Hy ed ot	Be C	John Wesley Sesker			a Mundell		
21215-0036 wild be filed within 7 Mental Hygiene. marked other than	To E	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or R			Zin Code)	
O the fact in	_	Arlene Virginia Mundell/Mother	2411 Terra Firma Road				
ore, MEss 1 and 2 soft Health as If item 27 her traums			ace of Disposition (Name of cemetery,	Date 2	20c. Location - City or	Town, State	
Baltimore, permit. Pages I as Department of Hes Important: If ite		Met	ematory or other place) Ero Crematory, INC. 2	il 30, 010	Baltimore,	MD	
Baltimo permit. Page Department of Important: injury or ott		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		0.0	·		
Balt permit. Depart Impor		Secr Sum	22 Name and Address of Facility Barranco & Sons, P. 495 Gov. Ritchie Hw	A. Sever	na Park Fu na Park M	neral Home	
Physician		23a. Part I. Enter the disease, or complications that caused the death. D	o not enter the mode of dying, such as cardiac or	respiratory arrest	, shock, or heart	Approximate Interval	
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Methadone int	oxication			Between Onset and Death	
Examiner		or condition resulting in death) Due to (or as a consequence of):					
		Sequentially list conditions, b			111		
	ine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				!	
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):					
ecuted and trans		d					
760, cate be ext physician the burial	/Medical	X UNPENDED AMENDED 23a,27,28a-	f,permE, g903 5/11/10	TT			
3760, ficate be g physici	× ×	IF FEMALE. J 23c. If yes, outcome of pregnal	ncy		23d. Date of delivery		
OX 687 eath certifi attending for use as t	ian	23b. Was decedent pregnant in the past 12 months? 1 Live birth 4 Pregnant at time of death	2 Fetal death 3 Ectopic pregnar	ncy	Month D.	ay Year	
Box 68 death certil he attending ed for use as	Physician	1 Yes 2 No 9 Unknown 9 Unknown	5 Other (Specify)				
or the		Part II. Other significant conditions contributing to death but not resu	ulting in the underlying cause given in Part I.	23e. Did toba	cco use contribute to the	ne cause of death?	
P.O. res that t signed b	d b			1 Yes	2 ✓ No 3 Proba	ably 4 Unknown	
ds require	Completed			24a. Was an		opsy findings available	
CO law law e has	ם			autopsy performe	ed? death?	impletion of cause of	
tal Recian: The certificate		25. Was case referred to medical	20.20	1 Yes 2	No 1 Yes	2 No	
ital sician s cert irecto	a	examiner? Hospital:	26.Place of Death (Check of R/Outpatient 3 DOA Other Nursing		aidana a Geografia		
of Vital Records, ng Physician: The law requir. Uter this certificate has been sincral director, page 2 should t	음	1 163 2 160	Todapation 5 Dort 4 Training	28d. Describe how	sidence 6 🗸 Other:	Scene	
On C tending eath. or: Af the fun	틸	1 Natural 5 Dending (Month, Day, Year)	1 Ves 2X No	unk	injury coodinou		
Division tal or Attendiu rs after death. al Director: A led in by the fu	<u>ig</u>	2 Accident Investigation RG 4/24/10 F	d 12:20 ath	28f Location (Stre	et and Number or Rur:	Route Number City	
Div pital or ours afte leral Dir filled in	ertification:	Suicide 6 Could not be determined (Specify) found at	h	or Town, State altimore	et and Number or Rura e)517 Baltio	Ave	
	O	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge,	10			1.	
To the Howithin 24 h To the Fur	Medical	one) 2 Medical Examiner: On the basis of examination and/					
To wit	\$	29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Mont	h, Day, Year)	
		D_M_M	O.C.M.E.	A	April 24, 2010		
0.12	h	30. Name and address of person who completed cause of death (Item 23	a)		•		
OHO!		Donna M. Vincenti, MD Assistant Medical Examin	ner 111 Penn Street, Baltimore, MD	21201			
	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 2 9 2010	1 1.41				
Regist	ıσι	MIN TO LOTO (KNOWN)	parker				

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 17, Day 2010 Year William H. Storck 4:36 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1720 Pleasant Plains Road Anne Arundel Annapolis Social Security Number 9. Birthplace (State or Foreign New unit or k If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1**X** M 2 □ F 94 Hours 119-01-6764 Min 12/15/7979 **Director** Usual Residence of Decedent 28a-f show Hygiene. other than "natural", or items 23a or 28a-f shov ---+ the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 ☐ Yes 2 🙀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1720 Pleasant Plains Road USA 21409 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Armed Forces' Black White etc. 1 Never Married 2 Married 1X Yes 2 □ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X☐ No Specify: If Yes, Give Year or Dates. Specify: White 3 Midowed 4 □ Divorced 41 - 64event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Tax Accountant Self Employed and Mental Hygie is marked other Be 17. Father's Name *(First, Middle, Last)* Henry Storck 18. Mother's Name (First, Middle, Maiden Surname)
Caroline Smith permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William P. Storck - Son 1718 Pleasant Plains Rd, Annapolis, MD 21409 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Baltimore Crematory 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4/20/2010 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licer 22. Name and Address of Facility John M. Taylor Funeral Home Midle 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) /ISSCMIN ATRO Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consciuence of and -transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending pl IF FEMALE: f yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy performed? Yes 2 K 2 🗌 No 1 🗌 Yes Division of Vital funeral director, 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🔀 No ည 1 Inpatient 2 ER/Outpatient 3 IDOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide After To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completed filled in by the fune. 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00060752 2010 ma A-SHEECK 30. Name and address of person who completed 14 suse of death (Item 23a) (Type, Print Garth A. Ashbeck ENINSULA HENDLY Man 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State APR 2 0 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ ADOLL Katherine M. Schneider 2000 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WIMDRE LOACHINGTON MEDICAL CENTER CHER BURNIE ANNE AZINISE 9. Birthplace (State or Foreign Country)
Texas If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Jul 9, 1922 7. Age (In vrs. last birthday) Funeral 1 □ M 2 😿 F Months Days Hours 488-24-2002 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director 10d. Inside City Limits notified 28a-f MD Anne Arundel Severna Park 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 510 White Oak Drive 21146 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural", Specify: Completed 3 Divorced 4 Divorced the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Education Teacher Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ of Health and Ments John H. Gassner Laura Henkel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leonard G. Schneider/Husband 510 White Oak Drive Severna Park, MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🛛 Cremation 3 ☐ Reproval April 2010 om State 4 Donation 5 Donation Other (Specify)/ Metro Crematory Baltimore, Swinature of uneral Se 22. Name and Address of Facility Tarranco 495 Gov. 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, o heart failure. List on one cause on each line. Interval Between Onset and Death ediate ause (Final disease or ondition resulting in death) Physician/ Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed lilled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjur) that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy autope, performed? 2 🗌 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 \sqrt{Yes} 2 \sqrt{No} Natural iniury 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) Hocota 9 leu burnie ろひし drive 31. Date filed (Month, Day, Ye State

Registrar

DHMH 17 Rev 1/2001